

## 3630. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E, Parts A and B, calculate title XVIII settlement for inpatient hospital services under PPS and title XVIII (Part B) settlement for medical and other health services. Worksheet E, Parts C, D, and E, calculate (for titles V, XVIII, and XIX) settlement for outpatient ambulatory surgery, radiology, and other diagnostic procedures. Worksheet E-3 computes title XVIII, Part A settlement for non-PPS hospitals, settlements under titles V and XIX, and settlements for title XVIII SNFs reimbursed under a prospective payment system.

Worksheet E consists of the following five parts:

- Part A - Inpatient Hospital Services Under PPS
- Part B - Medical and Other Health Services
- Part C - Outpatient Ambulatory Surgical Center
- Part D - Outpatient Radiology Services
- Part E - Other Outpatient Diagnostic Procedures

Application of Lesser of Reasonable Cost or Customary Charges.--Worksheet E, Parts B, C, D, and E, allow for the computation of the lesser of reasonable costs or customary charges (LCC) for services covered under Part B. Make a separate computation on each of these worksheets. In addition, make separate computations to determine whether the services on any or all of these worksheets are exempt from LCC. For example, the provider may meet the nominality test for the services on Worksheet E, Parts B and C only and, therefore, be exempt from LCC only for these services.

For those provider Part B services exempt from LCC for this reason, reimbursement for the affected services is based on 80 percent of reasonable cost net of the Part B deductible amounts.

3630.1 Part A - Inpatient Hospital Services Under PPS.--

**NOTE:** For SCH/MDH status change and/or geographical reclassification (see 42 CFR 412.102/103) subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04, and 5-7. (9/30/96)

Enter on lines 1 through 5 in column 1 the applicable payment data for the period applicable to SCH status. Enter on lines 1 through 5 in column 1.01 the payment data for the period in which the provider did not retain SCH status. The data for lines 1 through 5 must be obtained from the provider's records or the PS&R.

For cost reporting periods beginning on or after October 1, 2000, SCH providers must subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04, and 5-7, for cost reporting periods overlapping 9/30/2001, 9/30/2002 or 9/30/2003. Enter in column 1 the applicable payment data for the period prior to October 1 and enter in column 1.01, the applicable payment data for the period on or after October 1.

For cost reporting periods overlapping October 1, 2006, small rural MDH providers must subscript column 1 for lines 1-2, 3.21-3.24, 4.03-4.04 and 5-7 (42 CFR (412.106(d)(2)(iv)(D))). Enter in column 1 the applicable payment data for the period prior to October 1, 2006, and enter in column 1.01 the applicable payment data for the period on or after October 1, 2006.

Line Descriptions

Line 1--The amount entered on this line is computed as the sum of the Federal portion (DRG payment) paid for PPS discharges during the cost reporting period and the DRG payments made for PPS transfers during the cost reporting period. Beginning October 1, 1997, the formula for calculating indirect medical education will be modified annually beginning October 1 of each year. (The phrase "through October 1, 2001" was deleted in T15 from the end of previous sentence). To accommodate the change in the formula it is necessary to subscript line 1. On line 1 enter the payments for discharges occurring prior to October 1. (See the asterisks (\*) below for any

exceptions to the reporting of these payments.) If you answered yes to question 21.02 on Worksheet S-2, subscript column 1 and report the payments before the reclassification in column 1.01 and on or after the reclassification in column 1. For discharges occurring on or after April 1, 2001 through September 30, 2001 a modification has been made to the IME formula. See lines 1.07 and 1.08 for identifying payments made on or after that date. In addition, for discharges occurring on or after April 1, 2004 through September 30, 2004 a modification has been made to the DSH payment percentages. See lines 1.07 and 1.08 for identifying payments made on or after these dates.

Line 1.01--Enter the payment for discharges occurring on or after October 1 and before January 1.

Line 1.02--Enter the payments for discharges occurring on or after January 1.

The chart provided below is to assist with the placement of DRG amounts in accordance with the instructions for Worksheet E, Part A.

Cost Reports **Without** Dates of Services 4/1/2001 - 9/30/2001 or 4/1/2004 - 9/30/2004

DRG Payments	Line 1	Line 1.01	Line 1.02
Medicare Managed Care Payments	Line 1.03	Line 1.04	Line 1.05
Cost Reporting Period			
1/1 - 12/31	1/1 - 9/30	10/1 - 12/31	
2/1 - 1/31	2/1 - 9/30	10/1 - 12/31	1/1 - 1/31
3/1 - 2/28-29	3/1 - 9/30	10/1 - 12/31	1/1 - 2/28-29
4/1 - 3/31	4/1 - 9/30	10/1 - 12/31	1/1 - 3/31
5/1 - 4/30	5/1 - 9/30	10/1 - 12/31	1/1 - 4/30
6/1 - 5/31	6/1 - 9/30	10/1 - 12/31	1/1 - 5/31
7/1 - 6/30	7/1 - 9/30	10/1 - 12/31	1/1 - 6/30
8/1 - 7/31	8/1 - 9/30	10/1 - 12/31	1/1 - 7/31
9/1 - 8/31	9/1 - 9/30	10/1 - 12/31	1/1 - 8/31
10/1 - 9/30		10/1 - 12/31	1/1 - 9/30
11/1 - 10/31	10/1 - 10/31	11/1 - 12/31	1/1 - 9/30
12/1 - 11/30	10/1 - 11/30	12/1 - 12/31	1/1 - 9/30

Cost Reports **With** Dates of Services 4/1/2001 - 9/30/2001 or 4/1/2004 - 9/30/2004

DRG Payments	Line 1	Line 1.01	Line 1.02	Line 1.07
Medicare Managed Care Payments	Line 1.03	Line 1.04	Line 1.05	Line 1.08
Cost Reporting Period				
1/1 - 12/31	1/1 - 3/31	10/1 - 12/31		4/1 - 9/30
2/1 - 1/31	2/1 - 3/31	10/1 - 12/31	1/1 - 1/31	4/1 - 9/30
3/1 - 2/28-29	3/1 - 3/31	10/1 - 12/31	1/1 - 2/28-29	4/1 - 9/30
4/1 - 3/31		10/1 - 12/31	1/1 - 3/31	4/1 - 9/30
5/1 - 4/30	5/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 4/30
6/1 - 5/31	6/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 5/31
7/1 - 6/30	7/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 6/30
8/1 - 7/31	8/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 7/31
9/1 - 8/31	9/1 - 9/30	10/1 - 12/31	1/1 - 3/31	4/1 - 8/31
10/1 - 9/30		10/1 - 12/31	1/1 - 3/31	4/1 - 9/30
11/1 - 10/31	10/1 - 10/31	11/1 - 12/31	1/1 - 3/31	4/1 - 9/30
12/1 - 11/30	10/1 - 11/30	12/1 - 12/31	1/1 - 3/31	4/1 - 9/30

**NOTE:** Twelve month cost reporting periods that end in October and November or a 13 month cost reporting period which ends on these months must report payments for the ending months of October and November on line 1.

**NOTE:** A 13 month cost report that ends January 31 must report the payments for the 13th month (January 1- January 31) on line 1.02.

For short period cost reports, base the input of payment as if it was a 12 month cost report from the beginning date. Be sure lines 1 through 1.02, 1.03 through 1.05, and 3.21 through 3.23 reflect the same time period and the appropriate adjustment factor (10/97).

Hospitals receive payments for indirect medical education for managed care patients beginning January 1, 1998. Therefore, further subscripts are required to report the DRG payment that would have been made if the service had not been a managed care service. The PS&R will capture in conjunction with the PPS PRICER the simulated payments. Only a specified percentage of the simulated payment is allowed to be included, i.e., 20 percent for January 1, 1998, 40 percent for January 1, 1999, 60 percent for January 1, 2000, 80 percent for January 1, 2001, and 100 percent thereafter. (See the chart and exceptions identified with asterisks (\*) (\*\*)) above before reporting these payments on the lines below.)

Line 1.03--Enter the total managed care "simulated payments" from the PS&R prior to March 31 or October 1. Complete line 1.08 for cost reports that overlap April 1, 2001.

Line 1.04--Enter the total managed care "simulated payments" from the PS&R from October 1 and before January 1.

Line 1.05--Enter the total managed care "simulated payments" from the PS&R on or after January 1 but before April 1/October 1.

Complete line 1.08 for cost reports with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004.

Line 1.06--If you answered "yes" to line 55 of Worksheet S-2, and you did not receive the add-on payment during the year, report the additional amount eligible in accordance with CFR 412.107 on line 1.06 by multiplying the sum of lines 1 through 2.01 by .5 percent for services beginning in the government's fiscal year 1998 and .3 percent for 1999. If lines 1 through 2.01 reflect payment and you are no longer eligible, multiply that amount by .995025 for 1998 and .997024 for 1999 and subtract that result from the sum of lines 1 through 2.01 and enter the result as a negative.

Line 1.07--Enter the payment for discharges occurring on or after April 1, 2001 and before October 1, 2001 or April 1, 2004 through September 30, 2004.

Line 1.08--Enter the total managed care "simulated payments" from the PS&R on or after April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004.

Line 2--Enter the amount of outlier payments made for PPS discharges during the period. See 42 CFR 412, Subpart F for a discussion of these items. Report only the outlier payments attributable to discharges occurring prior to October 1, 1997. Report on line 2.01 the outlier payments received for discharges occurring on and after October 1, 1997.

Line 3--Enter the result of dividing the number of bed days available (Worksheet S-3, Part I, column 2, line 12) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

**NOTE:** Reduce the bed days available by nursery days (Worksheet S-3, Part I, column 2, line 11), swing bed days (Worksheet S-3, Part I, column 6, sum of lines 3 and 4), and the number of observation days (Worksheet S-3, Part I, column 6, line 26 for cost reporting periods beginning before October 1, 2004 *and beginning on or after October 1, 2009*, or Worksheet S-3, Part I, column 6.02, line 26 for cost reporting periods beginning on or after October 1, 2004, *and beginning before October 1, 2009*).

Indirect Medical Educational Adjustment--Calculate the amount of the additional payment relating to indirect medical education on lines 3 to 3.03. (See 42 CFR 412.105.) Calculate the IME adjustment only if you answered "yes" to line 25.01 on Worksheet S-2. For cost reporting periods ending on or before September 30, 1997, complete lines 3 to 3.03. For cost reporting periods which overlap October 1, 1997, and thereafter, skip lines 3.01 to 3.03 and complete lines 3.04 to 3.24.

Line 3.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. (See 42 CFR 412.105(f) for counting FTE.)

Line 3.02--Enter the indirect medical education percentage ( $1.89 \times \{(1 + \text{line } 3.01/\text{line } 3) \text{ to the } .405 \text{ power} - 1\}$ ).

Line 3.03--Multiply the percentage calculated on line 3.02 by the sum of lines 1 and 2 and subscripts.

Calculation of the adjusted cap in accordance with 42 CFR 412.105(f):

Line 3.04--Enter the FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. 42 CFR 412.105(f)(1)(iv) Effective for discharges occurring on or after April 1, 2000, adjust this count for the 30 percent increase for qualified rural hospitals. For cost reporting periods beginning on or after November 29, 1999, adjust for any increases due to primary care residents that were on approved leaves of absence. (42 CFR 412.105(f)(1)(iv) and (xi) respectively) Effective for discharges occurring on or after October 1, 2001, temporarily reduce the FTE count of a hospital that closed a program(s), if the regulations at 42 CFR 412.105(f)(1)(ix) are applicable.

Line 3.05--Enter the FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.79(e). For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(1), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995. For hospitals qualifying for a cap adjustment under 42 CFR 413.79(e)(2), the cap for each new program accredited or begun on or after January 1, 1995 and before August 6, 1997, is effective in the fourth program year of each of those new programs (see 66 FR, August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTE's that were already included in the cap on line 3.04. Also enter here the allopathic or osteopathic FTE count for residents in all years of a rural track program that meet the criteria for an add-on to the cap under 42 CFR 412.105(f)(1)(x). (If the rural track program is a new program under 42 CFR 413.79(l) and qualifies for a cap adjustment under 42 CFR 413.79(e)(1) or (3), do not report FTE residents in the rural track program on this line until the fourth program year. Report these FTEs on line 3.17). Also include here any temporary adjustment to the cap due to a hospital closing for cost reporting periods beginning before October 1, 2001.

Line 3.06--Enter the adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 **Federal Register**, page 26336, May 12, 1998.

Line 3.07--Enter the sum of lines 3.04 through 3.06 for all cost reporting periods ending prior to July 1, 2005 and for cost reporting periods ending on or after July 1, 2005, only if worksheet S-2, line 25.05 column 2 is "N". If the IME FTE cap was reduced under 42 CFR 412.105(f)(1)(iv)(B) due to unused residency slots, (Worksheet S-2, line 25.05, column 2 is "Y"), for cost reporting periods ending on or after July 1, 2005, enter the sum of the amounts from line 3.06 plus the amount on Worksheet E-3, Part VI, line 15.

Calculation of the allowable current year FTEs:

Line 3.08--Enter the FTE count for allopathic and osteopathic programs in the current year from your records for cost reporting periods beginning on or after October 1, 1997. Residents in new programs who were included in the cap (line 3.04) should be included on lines 3.08, 3.09, 3.11, 3.12, and prior years' counts on lines 3.15 and 3.16. These residents are not included after the rolling average. Do not include residents in the initial years of the new program. (42 CFR 412.105(f)(1)(iv) and/or (f)(1)(v).)

Lines 3.09 through 3.12 apply only to providers with cost reporting periods that overlap the October 1, 1997 effective date. Complete these lines in lieu of line 3.08. Do not include residents in the initial years of the program. **For cost reporting periods beginning on or after October 1, 1997, do not complete these lines.**

Line 3.09--For cost reporting periods beginning before October 1, enter the percentage of discharges to total discharges occurring prior to October 1. (10/97)

Line 3.10--For cost reporting periods beginning before October 1, 1997, enter the percentage of discharges to total discharges occurring on and after October 1. (10/97)

Line 3.11--Enter the FTE count net of dental and podiatry for the period identified in line 3.09. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.79(d).

Line 3.12--Enter the FTE count net of dental and podiatry for the period identified in line 3.10. Use the actual count as if counting for the entire year, or what would have been reported on line 3.08. Do not include intern and residents in the initial years of the program 42 CFR 413.79(d).

Line 3.13--Enter the FTE count for residents in dental and podiatric programs.

Line 3.14--Enter the result of the lesser of lines 3.07 or 3.08 added to line 3.13. If lines 3.09 through 3.12 are completed, enter the sum of (line 3.09 times line 3.11) plus the lesser of (line 3.10 times line 3.12) or (line 3.10 times line 3.07). Add that result to the amount on line 3.13. Calculate the rolling average count for cost reporting periods beginning on or after October 1, 1997.

Line 3.15--Enter the total allowable FTE count from line 3.14 or line 3.01 of the prior year. Do not include residents in the initial years of the program. However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 43 CFR 412.105(f)(i)(v)) expired, enter on this line the allowable FTE count from line 3.14 plus the count of FTE residents in that specific program included in line 3.17 of the prior year's cost report. If you had no approved teaching program make no entry (10/97). See comment for line 3.08. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0 (applicable for cost reporting periods ending before 6/30/2006).

Line 3.16--Enter the total allowable FTE count for the penultimate year from line 3.14 if that year ended on or after September 30, 1997. If you had no approved teaching program make no entry. Do not include residents in the initial years of the program (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 43 CFR 412.105(f)(i)(v) expired, enter on this line the allowable FTE count from line 3.14 plus the count of FTE residents in that specific program included in line 3.17 of the penultimate year's cost report. (10/97) See comment for line 3.08. If you did not have any FTE's reported for this period but you did have an approved teaching program, enter a (1) in column 0 (applicable for cost reporting periods ending before 6/30/2006).

Line 3.17--Enter the sum of lines 3.14 through 3.16 and divide by the number of these lines greater than zero, unless a 1 is entered in column zero on lines 3.15 and 3.16 then count those lines. (See 42 CFR 413.79(d).) Add to that result the number of FTE residents in the initial years of the program that meet the rolling average exception in 42 CFR 413.79(d)(5) and (e)(6). Effective for discharges occurring on or after October 1, 2001, add to this amount any temporary adjustments for FTE residents that were displaced by program or hospital closure (42 CFR 412.105(f)(1)(ix)).

For cost reporting periods ending on or after June 30, 2006, enter in column zero the number of FTE residents in the initial years of the program that meet the rolling average exception and temporary adjustments for FTE residents that were displaced by program or hospital closure, (See 42CFR 412.105(f)(1)(v)). Enter in column 1 the sum of lines 3.14 through 3.16 divided by three; add to this count the FTEs reported in column zero.

This change is date sensitive and column zero only applies to cost reporting periods ending on or after June 30, 2006.

Line 3.18--Enter the current year resident to bed ratio. Line 3.17 divided by line 3.

Line 3.19--In general, for cost reporting periods beginning on or after October 1, 1997, enter from the prior year cost report the intern and resident to bed ratio by dividing line 3.14 by line 3. However, if the provider is participating in training residents in a new medical residency training program(s) under 42 CFR 413.79(e), add to the numerator of the prior year intern and resident to bed ratio the number of FTE residents in the current cost reporting period that are in the initial period of years of a new program (i.e., the period of years is the minimum accredited length of the program). If the provider is participating in a Medicare GME affiliation agreement under 42 CFR 413.79(f), and the provider increased its current year FTE cap and current year FTE count due to this affiliation agreement, identify the lower of: a) the difference between the current year numerator and the prior year numerator, and b) the number by which the FTE cap increased per the affiliation agreement, and add the lower of these two numbers to the prior year's numerator (see FR Vol. 66, No. 148 dated August 1, 2001, page 39880). Effective for cost reporting periods beginning on or after October 1, 2002, if the current year is the first cost reporting period in which a receiving hospital trains FTE residents displaced by the closure of another hospital or program, then also adjust the numerator of the prior year ratio for the number of current year FTE residents that were displaced by hospital or program closure (42 CFR 412.105(a)(1)(iii)). Also, in the cost reporting period following the last year the receiving hospital's FTE cap is temporarily adjusted for the displaced residents, adjust the numerator of the prior year ratio by subtracting the displaced FTE residents reported on line 3.17 of the prior year's cost report.(42 CFR 412.105 (a)(1)(iv)). If no intern and resident to bed ratio was reported in the prior year, calculate the ratio using the FTE count for residents in the initial years of the new program. For prior year cost reporting periods ending prior to October 1, 1997, compute the ratio by dividing line 3.01 by line 3.

Line 3.20--For cost reporting periods beginning on or after October 1, 1997, enter the lesser of lines 3.18 or 3.19.

IME adjustment calculation for hospitals with cost reporting periods beginning prior to October 1. The multiplier of the adjustment factor defined in 42 CFR 412.105(d) is changed every October 1<sup>st</sup> for discharges occurring on and after: October 1, 1996 - 1.89; October 1, 1997 - 1.72; October 1, 1998 - 1.6; October 1, 1999 - 1.60; October 1, 2000 – through March 31, 2001 - 1.54, April 1, 2001 through September 30, 2001 – 1.66; and, on or after October 1, 2001 through September 30, 2002 – 1.6; and on or after October 1, 2002 through September 30, 2003 – 1.35; On or after October 1, 2003 through March 31, 2004 – 1.35; On or after April 1, 2004 through September 30, 2004 – 1.47; On or after October 1, 2004 through September 30, 2005 – 1.42; On or after October 1, 2005 through September 30, 2006 – 1.37; On or after October 1, 2006 through September 30, 2007 – 1.32; On or after October 1, 2007 – 1.35.

For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, an additional computation will be required for discharges occurring during these periods. See line 3.24 below and the revised payment chart on page 36-136.1 for completion of line 3.24.

Line 3.21--For payments reported on lines 1 and 1.03, enter the result of the following: The appropriate multiplier of the adjustment factor for the payment period identified on line 1 times  $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$  times  $\{\text{sum of (the amount on line 1) + (line 1.03 times the appropriate percentage identified in the paragraph prior to line 1.03) + Line 2.}^{**}\}$

Line 3.22--For payments reported on lines 1.01 and 1.04, enter the result of the following: The appropriate adjustment factor for the payment period identified on line 1.01 times  $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$  times  $\{\text{line 1.01} + (\text{line 1.04 times the appropriate percentage identified in the paragraph prior to line 1.03})\}$ .

Line 3.23--For payments reported on lines 1.02 and 1.05, enter the result of the following: The appropriate multiplier of the adjustment factor for the payment period identified on line 1.02 times  $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$  times  $(\text{line 1.02} + \text{line 1.05 times the appropriate percentage identified in the paragraph prior to line 1.03})$ .

\* For cost reporting periods beginning on or after October 1, 1997, replace  $\{(\text{line 3.14 divided by line 3})(\text{adjust line 3.14 by the interns and residents in the initial years of the program})\}$  with the ratio reported on line 3.20. \*\* For discharges prior to October 1, 1997, only; do not include outliers for purposes of the IME calculation for discharges occurring on and after October 1, 1997.

Line 3.24--Enter the sum of lines 3.21 through 3.23. For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, add to this result, the appropriate multiplier of the adjustment factor for the payment period identified on line 1.07 times  $\{(1 + \text{line 3.14}/\text{line 3}^*) \text{ to the } .405 \text{ power} - 1\}$  times  $\{\text{the sum of line 1.07} + (\text{line 1.08 times the appropriate percentage identified in the paragraph prior to line 1.03})\}$ . For cost reporting periods ending on or after July 1, 2005, add to this result the amount from Worksheet E-3, Part VI, line 23.

Disproportionate Share Adjustment.--Section 1886(d)(5)(F) of the Act, as implemented by 42 CFR 412.106, requires additional Medicare payments to hospitals with a disproportionate share of low income patients. Calculate the amount of the Medicare disproportionate share adjustment on lines 4 through 4.04. Complete this portion only if you answered yes to line 21.01 of Worksheet S-2. For cost reporting periods which overlap January 20, 2000, do not complete lines 4 through 4.03 and enter on line 4.04 the manually calculated DSH payment adjusted by the appropriate reduction. (See intermediary PM A-99-62 for proper determination of DSH adjustment.) For those hospitals experiencing a change in the DSH percentage as a result of the application of the BIPA provisions effective for services on and after April 1, 2001, or as a result

of the application of the MMA provisions effective for discharges on and after April 1, 2004, (i.e., geographic reclassification) subscript column 1 (add column 1.01) for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04 and apply the appropriate percentage for the DSH payment and reduction in accordance with the payment dates prescribed above. Review the payment chart on page 137 and lines 1, 1.01, 1.02 and 1.07 for proper reporting of payments. Do not subscript the column for lines 4.03 and 4.04, except as applicable for SCH\MDH and geographic reclassification.

Line 4--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your intermediary/*MAC*.)

Line 4.01--*For cost reporting periods beginning prior to October 1, 2004, and on or after October 1, 2009*, enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, *(plus Worksheet S-3, Part I, line 29, column 5 for cost reporting periods beginning on or after October 1, 2009)*, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 *(plus Worksheet S-3, Part I, line 29, column 6 for cost reporting periods beginning on or after October 1, 2009)* minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

For cost reporting periods beginning on or after October 1, 2004, *and beginning before October 1, 2009*, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, plus column 5.01, line 26, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12, plus column 6.01, line 26, minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

Line 4.02--Add lines 4 and 4.01 to equal the hospital's DSH patient percentage.

Line 4.03--Compare the percentage on line 4.02 with the criteria described in 42 CFR 412.106(c) and (d). Enter the percentage identified in the CFR to be applied against PPS payments. *Hospitals qualifying for DSH in accordance with 42 CFR 412.106(c)(2) (Pickle Amendment hospitals), if Worksheet S-2, line 21.01, column 2 is "Y" for yes, enter 35.00 percent on line 4.03.*

For cost reporting periods with dates of service in the period April 1, 2001, through September 30, 2001, or April 1, 2004, through September 30, 2004, enter in column 0 the percentage to be applied against PPS payment for the period April 1 through September 30. In addition, for MDH providers for cost reporting periods overlapping October 1, 2006, the rural 12 percent DSH payment cap does not apply for discharges occurring on or after October 1, 2006. Enter in column 1 the percentage to be applied for discharges occurring prior to October 1, 2006, and enter in column 1.01 the percentage to be applied for discharges occurring on or after October 1, 2006.

**NOTE:** For cost reporting periods ending on or after October 1, 2004 and before October 1, 2006, 42 CFR 412.102 provides for a transition to a rural DSH payment amount from a urban payment amount over two years, for hospitals that were considered urban under the MSA definition, but are considered rural under the CBSA definition. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2005 and 1/3 of the difference between the urban and rural operating DSH for FY 2006.

Line 4.04--Multiply line 4.03 by the sum of lines 1, 1.01, 1.02 and 2 and enter the result. For discharges occurring on or after October 1, 1997, multiply line 4.03 by the sum of lines 1, 1.01, and 1.02. For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, add to this amount the product of the payment percentage identified on line 4.03, column 0, applied to the payments identified on line 1.07. Reduce that amount for discharges occurring on or after October 1, 1997, by 1 percent; 2 percent for October 1, 1998, 3 percent for October 1, 1999; 3 percent for October

1, 2000 through March 31, 2001; 1 percent for April 1, 2001 through September 30, 2001; 3 percent for October 1, 2001 through September 30, 2002; and 0 (zero) percent thereafter. Review the payment chart on page 137 for the proper splitting of payments before and on or after October 1 and April 1 for those cost reports that overlap these dates in order to properly calculate the reduction.

High Percentage of ESRD Beneficiary Discharges Adjustment--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. When the average weekly cost per dialysis treatment changes within a cost reporting period, create a subscripted column 1.01 for lines 5.01 and 5.05.

Line 5--Enter total Medicare discharges reported on Worksheet S-3, Part I, excluding discharges for DRGs 302, 316, and 317, or effective October 1, 2007, excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages and 48520 and 48447).

Line 5.01--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding DRGs 302, 316, and 317, or effective October 1, 2007, excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447).

Line 5.02--Divide line 5.01, *sum of columns 1 and 1.01* by line 5, *sum of columns 1 and 1.01*. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 5.03--Enter the total Medicare ESRD inpatient days excluding DRGs 302, 316, and 317 or effective October 1, 2007, MS-DRGs 652, 682, 683, 684, and 685, as applicable.

Line 5.04--Enter the average length of stay expressed as a ratio to 7 days. Divide line 5.03 by line 5.01, *sum of columns 1 and 1.01*, and divide the result by 7 days.

Line 5.05--Enter the average weekly cost per dialysis treatment of \$401.43 (\$133.81 times the average *weekly* number of treatments (3)). See CR 6216, Transmittal 98, dated December 12, 2008. *See CR 6679, Transmittal 113, dated October 30, 2009, for the calendar year 2010 average weekly cost per dialysis treatment of \$405.45 (3 times rate per treatment of \$135.15).* This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.

Line 5.06--Enter the ESRD payment adjustment (line 5.04, column 1 times line 5.05, column 1 times line 5.01, column 1 plus, if applicable, line 5.04, column 1 times line 5.05, column *1.01* times line 5.01, column *1.01*).

Line 6--Enter the sum of lines 1, 1.01, 1.02, 1.07, 2, 2.01, 3.03 (for cost reporting periods which overlap October 1, 1997, and thereafter, substitute line 3.24 for line 3.03), 4.04 (subscripted columns), and 5.06. For cost reporting periods beginning in the government's fiscal year in 1998 and 1999 and you answered yes to line 55 of Worksheet S-2, add to this sum the amount on line 1.06, if applicable.

Line 7--Sole community hospitals are paid the highest rate of the Federal payment rate, the hospital-specific rate (HSR) determined based on a Federal fiscal year 1982 base period (see 42 CFR 412.73), or the hospital-specific rate determined based on a Federal fiscal year 1987 base period. (See 42 CFR 412.75.) For discharges occurring on or before October 1, 2006, Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 50 percent of the amount of the excess over the Federal rate of the higher of either the 1982 base period, or the 1987 base period hospital specific rate. For discharges occurring on or after October 1, 2006, Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 75 percent of the amount of the excess over the Federal rate of the highest rate for the 1982, 1987 or 2002 base period hospital specific rate. For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments.

For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your fiscal intermediary. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. For new hospital providers established after 1987, do not complete this line. Use the higher of the hospital-specific rate based on cost reporting periods beginning in FY 1982 or FY 1987. Use the hospital-specific rate (operating cost per discharge divided by the case mix index for 1982 or 1987, as applicable) updated to the beginning of the cost reporting period and adjusted for budget neutrality, if applicable, in this calculation. For services rendered on or after October 1, 2003, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, or 1996.

Additionally, for sole community hospitals only for cost reporting periods beginning on or after January 1, 2009, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, 1996, or 2006. (See 42 CFR 412.78.)

For MDH discharges occurring on or after October 1, 2006, and before October 1, 2011, an MDH can use a FY 2002 hospital specific rate.

Line 7.01--In addition to the comparison of 1982 and 1987, sole community hospitals can compare the hospital specific rate for cost reporting periods beginning in FY 1996 (CFR 412.77). For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003, enter on this line the hospital-specific payment amount based on the cost reporting period beginning in FY 1996 as supplied by your fiscal intermediary. For services rendered on or after October 1, 2003, do not use this line, but rather use line 7.

Line 8--For SCHs, enter the greater of line 6 or 7. For MDHs (for discharges occurring on or after October 1, 1997, and before October 1, 2006), if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 50 percent of the amount that line 7 exceeds line 6. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2011, if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 75 percent of the amount that line 7 exceeds line 6. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 6.

For hospitals subscribing column 1 of line 6 due to a change in geographic location, this computation will be computed separately for each column, and the sum of the calculations will be entered in column 1 of this line.

For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003 - The transition into the FY 1996 rate is actually a blend based on discharges for FY 2001 (October 1, 2000 - September 30, 2001) of 75 percent of the higher of the 1982, 1987, or Federal amount and 25 percent of 1996. For FY 2002 (October 1, 2001 - September 30, 2002), the blend is 50/50, and for FY 2003 (October 1, 2002 - September 30, 2003) the blend is 25/75.

If line 7.01 is greater than lines 6 and 7, enter the higher of lines 7 or 6 multiplied by the appropriate blend percentage. Add to this amount, the amount on line 7.01 multiplied by the appropriate FY 1996 HSR blend percentage. (42 CFR 412.92) If line 7.01 is not greater than lines 6 or 7, enter the greater of lines 6 or 7. If line 6 is greater than lines 7 and 7.01, enter that amount on this line.

Line 9--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 10--Enter the exception payment for inpatient program capital, if applicable, from Worksheet L, Part IV, line 13 for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, if the provider continues to

qualify for the additional payment for extraordinary circumstances pursuant to 42 CFR 412.348(e) enter the exception payment for inpatient program capital from Worksheet L, Part IV, line 13. If the provider qualifies for the special exceptions payment pursuant to 42 CFR 412.348(g) enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

Line 11--Enter the amount from Worksheet E-3, Part IV, line 24. Complete this line only for the hospital component.

Obtain the payment amounts for lines 11.01 and 11.02 from your fiscal intermediary.

Line 11.01--Enter the amount of Nursing and Allied Health Managed Care payments if applicable.

Line 11.02--Enter the special add-on payment for new technologies (see change request 2301).

Line 12--Enter the net organ acquisition cost from Worksheet(s) D-6, Part III, column 1, line 61.

Line 13--Enter the cost of teaching physicians from Worksheet D-9, Part II, column 3, line 16.

Line 14--Enter on the appropriate Worksheet E, Part A, the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 for the hospital and line 31 for the subproviders.

Line 15--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 16--Enter the sum of lines 8 through 15.

Line 17--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 12. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 17 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 17.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-6, Part III, line 58.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 17 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 19--Enter from the PS&R or your records the deductibles billed to program patients.

Line 20--Enter from the PS&R or your records the coinsurance billed to program patients.

Line 21--Enter the program reimbursable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 21 and 21.01 will be negative.

Line 21.01--Enter line 21 (including negative amounts) times 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999, and 70 percent for October 1, 2000 and thereafter.

Line 21.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 21. (4/1/2004b)

Line 22--Enter the sum of lines 18 and 21.01 minus the sum of lines 19 and 20.

Line 23--Enter the programs share of any recovery of accelerated depreciation applicable to prior periods paid under reasonable cost or the hold harmless methodology under capital PPS resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136 - 136.16.)

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. Effective for discharges occurring on or after October 1, 2008, enter on line 24.98 the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in Change Request 5860, transmittal 1509, dated May 9, 2008. Only FI/contractors complete line 24.99 by entering the sum of lines 52, 53, 55, and 56.

Line 25--If you are filing under the fully prospective payment methodology for capital costs or on the basis of 100 percent of the Federal rate under the hold harmless methodology, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. For providers paid under the hold harmless reasonable cost methodology, compute gains or losses on the disposal of old assets

in accordance with CMS Pub. 15-1, §§132-134.4. For gains or losses on new capital, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. (See 42 CFR 413.134(f)(1).)

**NOTE:** Section 1861 (v) (1) (O) of the Act sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997, and restricts the gain or loss on the sale or scrapping of assets.

Enter the amount of any excess depreciation taken as a negative amount.

Line 26--Enter the amount due you (i.e., the sum of the amounts on line 22 plus or minus lines 24 and 25 minus line 23).

Line 27--Enter the sequestration adjustment amount, if applicable.

Line 28--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 28.01. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

Line 29--Enter line 26 minus the sum of lines 27 and 28. Transfer to Worksheet S, Part II.

Line 30--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

Lines 31 through 49 were intentionally skipped to accommodate future revisions to this worksheet.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 50 THROUGH 56 ARE FOR CONTRACTOR USE ONLY.**

Line 50--Enter the original operating outlier amount from line 2.01 sum of all columns of this worksheet.

Line 51--Enter the original capital outlier amount from worksheet L, part I, line 3.01.

Line 52--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7

Line 53--Enter the capital outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7

Line 54--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7.)

Line 55--*Enter the time value of money for operating related expenses.*

Line 56--*Enter the time value of money for capital related expenses.*

**NOTE:** If a cost report is reopened more than one time, subscript lines 50 through 56, respectively, one time for each time the cost report is reopened.

3630.2 Part B - Medical and Other Health Services--Use Worksheet E, Part B, to calculate reimbursement settlement for hospitals, subproviders, and SNFs.

Use a separate copy of Worksheet E, Part B, for each of these reporting situations. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. Enter check marks in the appropriate spaces at the top of each page of Worksheet E to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers. OPD PPS services furnished on or after 8/1/2000 is only applicable for hospital title XVIII providers. (See BBRA §202) For services rendered on or after August 1, 2000, for purposes of prospective payment for outpatient services, if the cost reporting periods overlap any of the effective dates, complete subscribed column 1.01 for lines 1.01 through 1.06 only and make a separate transitional corridor or geographic reclassification (urban to rural only) (42 CFR 412.103 and 412.230) payment calculation for the appropriate periods. This may result in multiple subscribed columns. Order the subscribed columns chronologically as the transition dates or geographic reclassification relate to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 9, 9.01, 9.02 and 9.03, etcetera

### Line Descriptions

Line 1--Enter the cost of medical and other health services for title XVIII, Part B. This amount also includes the cost of ancillary services furnished to inpatients under the medical and other health services benefit of Medicare Part B. These services are covered in this manner for Medicare beneficiaries with Part B coverage only when Part A benefits are not available. Obtain this amount from Worksheet D, Part V, line 104, columns 9, 9.02 and 11, for hospitals and enter in column 1. Add to the amount reported in column 1 the amount from Worksheet D, VI, line 3 (and/or 3.01 as applicable) for services rendered through March 31, 2001 and on or after January 1, 2003. For SNFs transfer the amount from Worksheet D, Part V, column 9 plus Worksheet D, Part VI, lines 3. For RPCH/CAH providers electing the all-inclusive method of payment for outpatient services prior to October 1, 1997 (see Worksheet S-2, lines 30 through 30.02), obtain this amount from Worksheet C, Part V, column 7, line 108.

CAHs are not subject to transitional corridor payments, therefore lines 1.01 through 1.07 do not apply to CAHs. Transfer Worksheet D, Part V, column 9, line 104 and Worksheet D, Part VI, lines 3 and 3.01.

Line 1.01--Enter the medical and other health services for services rendered on or after August 1, 2000, from Worksheet D, Part V, column 9.01, line 104 added to the amount reported on Worksheet D, Part VI, line 3.01; line 3 for cost reporting periods beginning on or after April 1, 2001. Subtract from this amount outpatient pass through costs reported on Worksheet D, Part IV, line 101, columns 9 and subscripts as applicable.

Line 1.02--Enter the gross PPS payments received including payment for drugs, device pass through payments, and outliers.

Contractors only, add or subtract as applicable to the gross PPS payments the total outlier reconciliation amount from line 54.

Line 1.03--Enter the hospital specific payment to cost ratio provided by your intermediary. If a new provider does not file a full cost report for a cost reporting period that ends prior to January 1, 2001, the provider is not eligible for transitional corridor payments and should enter zero (0) on this line. (See PM A-01-51)

Line 1.04--Line 1.01 times line 1.03.

If line 1.02 is < line 1.04 complete lines 1.05 and 1.06. Otherwise do not complete lines 1.05 and 1.06.

Line 1.05--Line 1.02 divided by line 1.04.

Line 1.06--Enter the transitional corridor payment amount calculated based on the following: For purposes of determining the bed count for small rural hospitals see 42 CFR §412.105(b).

For cost services rendered from January 1, 2006 through December 31, 2008, calculate this line when the response to Worksheet S-2, line 21.06 is "Y".

For services rendered August 1, 2000, through December 31, 2001:

- a. Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is  $\leq 100$ , enter the difference of line 1.04 minus line 1.02; or
- b. Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- b. If line 1.05 is  $\geq 90$  percent but  $< 100$  percent, enter 80 percent of (line 1.04 minus line 1.02).
- c. If line 1.05 is  $\geq 80$  percent but  $< 90$  percent, enter the result of 71 percent of (line 1.04 minus 70 percent of (line 1.02)).
- d. If line 1.05 is  $\geq 70$  percent but  $< 80$  percent, enter the result of 63 percent of (line 1.04 minus 60 percent of (line 1.02)).
- e. If line 1.05 is  $< 70$  percent, enter 21 percent of line 1.04.

For services rendered January 1, 2002, through December 31, 2002:

- a. If line 1.02 is  $<$  line 1.04, Worksheet S-2, line 21 response is 2 (rural hospital) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is  $\leq 100$ , enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is  $<$  line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- c. If line 1.05 is  $\geq 90$  percent but  $< 100$  percent, enter 70 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is  $\geq 80$  percent but  $< 90$  percent, enter the result of 61 percent of (line 1.04 minus 60 percent of (line 1.02)).
- e. If line 1.05 is  $< 80$  percent, enter 13 percent of line 1.04 .

For services rendered January 1, 2003, through December 31, 2003:

- a. If line 1.02 is  $<$  line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet E, Part A, line 3 is  $\leq 100$  enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is  $<$  line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

For all other hospital enter one of the following:

- c. If line 1.05 is  $\geq 90$  percent but  $< 100$  percent, enter 60 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is  $< 90$  percent, enter 6 percent of line 1.04.

For services rendered on or after January 1, 2004 for cancer or children's hospitals only:

- a. If line 1.02 is  $<$  line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

For services rendered January 1, 2004, through December 31, 2005, for small rural hospitals and small rural SCHs:

- a. If line 1.02 is  $<$  line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet E, Part A, line 3 is  $\leq 100$  enter the result of line 1.04 minus line 1.02.
- b. If line 1.02 is  $<$  line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is  $\leq 100$ , and Worksheet S-2, line 26 is  $\geq 1$  (sole community hospitals (SCH)) enter the result of line 1.04 minus line 1.02.

For cost reporting periods beginning on or after January 1, 2004, through services rendered on or before December 31, 2005, for rural SCHs:

- a. If line 1.02 is  $<$  line 1.04 or Worksheet S-2, line 26 response is  $\geq 1$  (number of periods SCH status in effect) enter the result of line 1.04 minus line 1.02.

**NOTE:** For purposes of TOPs, a hospital is considered rural if it is geographically rural, classified to rural for wage index purposes, or classified to rural for the standardized amount purposes. For example, a hospital that is geographically rural is always considered rural for TOPs, even if it is reclassified to urban for the wage index and/or standardized amount. A hospital that is geographically urban, but reclassified to rural for the wage index and/or standardized amount, is considered rural for purposes of TOPs.

In accordance with DRA 2005, section 5105, as amended by MIPPA 2008, section 147, for services rendered January 1, 2006, through December 31, 2009, rural hospitals with 100 or fewer beds that are not SCHs are entitled to hold harmless TOPs:

- a. For services rendered January 1, 2006, through December 31, 2006, if Worksheet S-2, line 21.06, is "Y", enter 95 percent of (line 1.04 minus line 1.02).
- b. For services rendered January 1, 2007, through December 31, 2007, if Worksheet S-2, line 21.06, is "Y", enter 90 percent of (line 1.04 minus line 1.02).
- c. For services rendered January 1, 2008, through December 31, 2009, if Worksheet S-2, line 21.06, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

In accordance with MIPPA 2008, section 147, for services rendered January 1, 2009, through December 31, 2009, SCHs with 100 or fewer beds are entitled to hold harmless TOPs:

- a. For services rendered January 1, 2009, through December 31, 2009, if Worksheet S-2, line 21.07, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

Line 1.07--Enter the pass through amount from worksheet D, Part IV, columns 9, 9.01 and 9.02, line 101.

Line 2--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

<u>Provider/Component</u>	<u>Title XVIII Hospital</u>	<u>Title XVIII Subprovider</u>	<u>Title XVIII Skilled Nursing Facility</u>
Hospital	Part I, col. 9, line 9 plus line 24; or Part II, col. 7, line 34; or Part III, col. 6, line 41	Part I, col. 9, line 10; or Part II, col. 7, line 35, or Part III, col. 6, line 42	Part I, col. 9, line 12; or Part II, col. 7, line 37; or Part III, col. 6, line 44

Line 3--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 2, line 61 when Worksheet E is completed for the hospital or the hospital component of a health care complex. Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 4--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost (see 42 CFR 415.160 and CMS Pub. 15-I, §2148), enter the amount from Worksheet D-9, Part II, column 3, line 17.

Line 5--Enter the sum of lines 1 through 4 excluding subscripts in column 1.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

**NOTE:** RPCHs/CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is an RPCH/CAH, do not complete lines 6 through 16. Instead, enter on line 17 the amount computed on line 5.

#### Line Descriptions

**NOTE:** If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter the total reasonable cost from line 5 directly on line 17. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 6 through 10--These lines provide for the accumulation of charges which relate to the reasonable cost on line 5.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-I, §§2570-2577.)

Line 6--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 5 and 5.01 (for hospitals and subproviders with cost reporting periods which overlap October 1, 1997, for ambulance services, and SNFs with cost reporting periods beginning prior to January 1, 1998), line 104 and Worksheet D, Part VI, line 2. For cost reporting periods overlapping 8/1/2000 and after, for hospital and subprovider services, enter the sum of D, Part V, columns 5, 5.02, and 10, line 104, plus D, Part VI, line 2.

For cost reporting periods beginning 1/1/99 for SNF services enter the sum of Worksheet D, Part V, column 5, line 104 and D, Part VI, line 2.

**NOTE:** If the amounts on Worksheet D, Part V include charges for professional services, eliminate the amount of the professional component from the charges entered on line 6. Submit a schedule showing these computations with the cost report.

Line 7--Enter zero (0) on this line because the hospital/component cannot bill separate charges for services of residents (in unapproved or approved programs) which are reimbursed under Part B.

Line 8--When Worksheet E is completed for a CTC hospital component for title XVIII, enter the organ acquisition charges from Worksheet D-6, Part III, column 4, line 61.

Line 9-- Enter zero (0) on this line because the hospital/component cannot bill separate charges for the direct patient care services rendered by physicians in teaching hospitals under the election described in 42 CFR 415.160.

Line 10--Enter the sum of lines 6 through 9.

Lines 11 through 14--These lines provide for the reduction of program charges when you do not actually impose such charges in the case of most patients liable for payment for services on a charge basis or fail to make reasonable efforts to collect such charges from those patients. If line 13 is greater than zero, multiply line 10 by line 13, and enter the result on line 14. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 11 through 13. Enter on line 14 the amount from line 10. In no instance may the customary charges on line 14 exceed the actual charges on line 10. (See 42 CFR 413.13(e).)

Line 15--Enter the excess of the customary charges over the reasonable cost. If line 14 exceeds the sum of lines 1 and 3, enter the difference.

Line 16--Enter the excess of reasonable cost over the customary charges. If the sum of lines 1 and 3, exceeds line 14, enter the difference.

Line 17-- Enter the amount from line 5, less any amount on reported on line 16 for hospital/services subject to LCC.

For hospital/services that are not subject to LCC in accordance with 42 CFR 413.13 (e.g., CAHs or nominal charge public or private hospitals identified on Worksheet S-2, lines 47-51), enter the reasonable costs from line 5.

For CAHs with cost reporting periods beginning on or after January 1, 2004, enter on this line 101 percent of line 5. (1/1/2004b)

Line 17.01--Enter the sum of lines 1.02, 1.06, and 1.07, all columns.

Line 18--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for coinsurance enter on this line the full coinsurance amount not the discounted amount.

Line 18.01--Enter the deductible and coinsurance relating to the amounts reported on line 17.01.

**NOTE:** If these services are exempt from LCC as a result of charges being equal to or less than 60 percent of cost (refer to Worksheet S-2, lines 47-51, columns 1-5, as applicable), enter the Part B deductibles billed to program beneficiaries only. Do not enter any Part B coinsurance. For CAHs with cost reporting periods beginning on or after 7/1/2002, enter the deductibles on line 18 and the coinsurance on line 18.01.

Line 19--Subtract line 18 and 18.01 from line 17 and 17.01 respectively.

**NOTE:** If these services are exempt from LCC, line 17 minus line 18 times 80 percent. Add to that result line 17.01 minus line 18.01.

For critical access hospitals (CAHs), with cost reporting periods beginning before July 1, 2002, exempt from LCC, multiply 80 percent times the result of line 17 minus (sum of line 18 plus Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3). Add back Worksheet D, Part V, column 9, lines 44, 45, and subscripts, plus Worksheet D, Part VI, line 3. Prorate on a days to days basis lab services for cost reporting periods overlapping 11/29/99. For cost reporting periods beginning on or after 11/29/2004 no prorating is required.

For CAHs with cost reporting periods beginning on or after July 1, 2002, and before January 1, 2004, enter the lesser of (line 17 minus the sum of lines 18 and 18.01) or 80 percent times the result of (line 17 minus line 18 minus lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus vaccine cost (Worksheet D, Part VI, line 3). Add back the aforementioned lab and vaccine cost).

For CAHs with cost reporting periods beginning on or after January 1, 2004, enter the lesser of (line 17 minus the sum of lines 18 and 18.01) or 80 percent times the result of (line 17 minus line 18 minus 101% of lab cost (Worksheet D, Part V, column 9, lines 44, 45, and subscripts) minus 101% of vaccine cost (Worksheet D, Part VI, line 3). Add back the aforementioned lab and vaccine cost). (1/1/2004b)

Line 20--This line is used to combine the amounts for medical and other health services, outpatient ambulatory services, outpatient radiology services, and other outpatient diagnostic procedures, for services rendered prior to August 1, 2000. Enter in column 1 only the sum of the amounts from Worksheet E, Part C, columns 1 plus 1.01, line 21; Part D, columns 1 plus 1.01, line 21; and Part E columns 1 plus 1.01, line 21. For services after August 1, 2000, make no entry.

Line 21--Enter in column 1 the amount from Worksheet E-3, Part IV, line 25. Complete this line for the hospital component only.

Line 22--Enter in column 1 the amount from Worksheet E-3, Part IV, line 11. Complete this line for the hospital component only.

Line 23--Enter in column 1 the sum of columns 1 and 1.01, lines 19 through 22.

Line 24--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- o Workmens' compensation,
- o No fault coverage,
- o General liability coverage,
- o Working aged provisions,
- o Disability provisions, and
- o Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, the services are treated as if they were non-program services for cost reporting purposes only. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient charges in total charges but not in program charges. In this situation, enter no primary payer payment on line 26. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer

payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 26.

Line 25--Enter line 23 minus line 24.

Line 26--Enter the amount of reimbursable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 9.

Line 27--Enter from your records reimbursable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 26. Bad debts associated with ambulance services rendered on or after April 1, 2002 (implementation of the cost/fee blend) are not allowable. If recoveries exceed the current year's bad debts, line 27 and 27.01 will be negative.

Line 27.01--Multiply the amount (including negative amounts) on line 27 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and thereafter (hospitals and subproviders only). The reduction does not apply to Critical Access Hospitals.

Line 27.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27. (4/1/2004b)

Line 28--Enter the sum of lines 25, 26 and 27 or 27.01(hospitals and subproviders only).

Line 29--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. For cost reporting periods ending on or after June 30, 2006, enter on line 30.99 the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.

Line 31--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.) Enter the amount of any excess depreciation taken as a negative amount in parentheses ( ).

Line 32--Enter the result of line 28, plus or minus lines 30 and 31 minus lines 29 and 30.99. Line 30.99 would only be included for cost reporting periods ending on or after June 30, 2006.

Line 33--Enter the sequestration adjustment amount, if applicable.

Line 34--Enter interim payments from Worksheet E-1, column 4, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 34.01. For intermediary purposes it will be necessary to make a reclassification of the bi-weekly pass through payments from Part A

to Part B and report that Part B portion on line 34.01. Maintain the necessary documentation to support the amount of the reclassification.

Line 35--Enter line 32 minus the sum of lines 33 and 34. Transfer this amount to Worksheet S, Part II, column 3, line as appropriate.

Line 36--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 50 THROUGH 54 ARE FOR CONTRACTOR USE ONLY.** (Effective for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009.)

Line 50--Enter the original outlier amount from line *1.02* sum of all columns of this worksheet.

Line 51--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.)

Line 53--*Enter the time value of money.*

Line 54--Enter sum of lines 51 and 53.

**NOTE:** If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

**3630.3 Part C - Outpatient Ambulatory Surgical Center.**--Use this worksheet to calculate reimbursement settlement for outpatient ambulatory surgery for titles V, XVIII, and XIX for the hospital and/or subprovider for services rendered prior to August 1, 2000; otherwise do not complete.

**NOTE:** Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services (see Worksheet S-2, lines 30 through 30.02), and CAHs do not complete this worksheet.

As required by §§1833(a)(4), 1832(a)(2)(F), and 1833(I) of the Act, payment for facility services furnished in connection with covered ASC procedures furnished by hospitals on an outpatient basis is based on the lesser of the outpatient cost or charges (in the aggregate) net of cost sharing or a blend of hospital cost and ASC rates at 42/58. (See CMS Pub. 15-I, §2830.3.) For cost reporting periods that end on or after October 1, 1997, and before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For all cost reporting periods that begin on or after October 1, 1997, continue to use the subscripted column and no longer complete column 1.

#### Line Descriptions

Line 1--Enter the standard overhead amounts from the PS&R report or from your records. Payments to ASCs for covered procedures are made on the basis of prospectively set rates known as standard overhead amounts (ASC fees). (See CMS Pub. 15-I, §2830.3.)

Line 2--Enter in column 1 the deductibles billed to the program for services prior to October 1, 1997. For column 1.01, do not complete this line.

Line 3--Line 1 minus line 2.

Line 4--Enter 80 percent of line 3 in column 1. For column 1.01 do not complete this line.

Line 5--This amount is the ASC portion of the blended amount. The ASC portion of the blended amount is 58 percent of the amount on line 4 of column 1 and line 1 of column 1.01.

Line 6--Enter the amount of the outpatient ASC cost from Worksheet D, Part V, columns 6 and 6.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges for the same services for outpatient ambulatory surgical procedures only if that amount is lower than the blended ASC amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

If you bill an all-inclusive rate or bill gross departmental charges and reflect a discount on the bill, you must, when billing Medicare, show gross departmental charges for each service on the bill. Identify the difference between the sum of these gross charges and the net amount you wish to collect. Also maintain a memorandum record when you bill an all-inclusive charge to non-Medicare patients. Always use the gross departmental charges for cost apportionment purposes. Show the discount amount in the customary charge computations, as appropriate.

**NOTE:** If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges which relate to reasonable cost on line 6 from Worksheet D, Part V, columns 2 and 2.01 (if applicable), line 104, in columns 1 (if applicable) and 1.01 respectively.

**NOTE:** If the amounts on Worksheet D, Part V, include charges for professional services, eliminate the amount of the professional component from the charges entered on line 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of the customary charges over the reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

**NOTE:** If these services are exempt from LCC, enter the reasonable cost from line 6.

Line 15--Enter in column 1 the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries for outpatient ambulatory surgical procedures. **DO NOT INCLUDE** deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on this line reflects coinsurance based on 20 percent of full charges, not discounted charges. Make no entry for column 1.01.

**NOTE:** If these services are exempt from LCC, enter the Part B deductibles from line 2. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1 and enter the amount on line 14 for column 1.01.

**NOTE:** If these services are exempt from LCC, subtract the deductibles reported on line 15 from line 14, and multiply the result by 80 percent for column 1 only.

Line 17--Enter 42 percent of line 16.

Line 18--Enter the sum of lines 5 and 17.

Line 19--Enter the lesser of lines 16 or 18 in columns 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1, enter the amount reported on line 19. In column 1.01, subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductibles reported on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII to Worksheet E, Part B, line 20; titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

**3630.4 Part D - Outpatient Radiology Services.**--Use this worksheet to calculate reimbursement settlement for outpatient radiology services for the hospital and/or subprovider for titles V, XVIII, and XIX, for services rendered prior to August 1, 2000; otherwise do not complete this form.

**NOTE:** Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services (see Worksheet S-2, lines 30 through 30.02) and CAHs do not complete this worksheet.

As required by §§1833(a)(2)(E) and 1833(n) of the Act, a payment methodology is imposed for radiology services performed on an outpatient basis by hospitals. Aggregate payment for radiology services performed in a hospital on an outpatient basis is based on the lower of (1) the hospital's reasonable cost or customary charges (in the aggregate) net of cost sharing, or (2) a blend of the hospital's outpatient radiology costs or its charges (whichever are less) net of (a) deductibles and coinsurance and (b) 62 percent of the physicians' fee schedule net of cost sharing as if the services were performed in a physician's office in the same locality. The blend consists of 42 percent hospital-specific cost and 58 percent fee schedule. For cost reporting periods that end on or after October 1, 1997, and on or before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For all cost reporting periods that begin on or after October 1, 1997, continue to use the subscripted column and no longer complete column 1.

Line Descriptions

Line 1--Enter the fees from the PS&R or your records in columns 1 and 1.01 for services rendered before October 1 and on or after October 1, 1997, respectively.

Line 2--Enter 62 percent of the amount on line 1 and 1.01

Line 3--Enter the deductibles billed to program patients in column 1 only. Obtain this amount from the PS&R or from your records.

Line 4--Enter 80 percent of the result of line 2 minus line 3 in column 1. Make no entry in column 1.01.

Line 5--This amount is the blended charge proportion. Enter 58 percent of line 4 in column 1 and 58 percent of the amount on line 2, column 1.01.

Line 6--Enter the amount of the outpatient radiology cost from Worksheet D, Part V, columns 7 and 7.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services for outpatient radiology services only if that amount is lower than the blended amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

**NOTE:** If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges that relate to reasonable cost on line 6 from Worksheet D, Part V, columns 3 and 3.01 (if applicable), line 104 in columns 1(if applicable) and 1.01 respectively.

**NOTE:** If the amounts on Worksheet D, Part V, include charges for professional services, eliminate the amount of the professional component from the charges entered on line 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of customary charges over reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

**NOTE:** If these services are exempt from LCC, enter the reasonable costs from line 6.

Line 15--Enter the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries in column 1 only. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on this line reflects coinsurance based on 20 percent of full charges, not discounted charges.

**NOTE:** If these services are exempt from LCC, enter the Part B deductibles from line 3. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1. Enter the amount from line 14 for column 1.01.

**NOTE:** If these services are exempt from LCC, subtract the deductibles included on line 15 from line 14, and multiply the result by 80 percent for column 1 only.

Line 17--Enter 42 percent of line 16 in column 1 and 1.01.

Line 18--Enter the sum of lines 5 and 17 for columns 1 and 1.01.

Line 19--Enter the lesser of lines 16 or 18 in column 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1, enter the amount reported on line 19. In column 1.01, subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductibles reported on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII to Worksheet E, Part B, line 20; and for titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

**3630.5 Part E - Other Outpatient Diagnostic Procedures.**--This worksheet calculates reimbursement settlement for other outpatient diagnostic procedures for both hospital and/or subprovider, for services rendered prior to August 1, 2000; otherwise do not complete this worksheet. As required by §§1833(a)(2)(E) and 1833(n) of the Act, payment for other diagnostic procedures performed in a hospital on an outpatient basis is based on the lower of (1) the hospital's reasonable cost or customary charges (in the aggregate) net of cost sharing, or (2) a blend of the hospital's other outpatient diagnostic procedures costs or its charges, if less (hospital-specific), and 42 percent of the physician fee schedule, net of cost sharing for the same procedures as if the procedures were performed in a physician's office in the same locality. The blend consists of 50 percent hospital-specific cost and 50 percent fee schedule. For cost reporting periods that end on or after October 1, 1997, and on or before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For cost reporting periods that begin on or after October 1, 1997, continue to use the subscripted column and no longer complete column 1.

**NOTE:** Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services and CAHs (see Worksheet S-2, lines 33 through 33.02) do not complete this worksheet.

### Line Descriptions

**Line 1**--Enter the fee schedule amounts from the PS&R or from your records in columns 1 and 1.01 for services rendered before October 1 and on and after October 1, 1997, respectively.

**Line 2**--Enter 42 percent of the amount on line 1.

**Line 3**--Enter in column 1 the deductibles billed to program patients. Obtain this amount from the PS&R or from your records.

**Line 4**--Enter in column 1 80 percent of the result of line 2 minus line 3. No entry is required for column 1.01.

**Line 5**--This amount is the blended charge proportion. Enter 50 percent of line 4 in column 1 and 50 percent of line 2 in column 1.01.

**Line 6**--Enter the amount of the outpatient radiology cost from Worksheet D, Part V, columns 8 and 8.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

**Computation of Lesser of Reasonable Cost or Customary Charges.**--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services for other outpatient diagnostic procedures only if the amount is lower than the blended amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(b)(2) or customary charges as defined in 42 CFR 413.13(b)(1).

**NOTE:** If the medical and other health services reported here qualify for exemption from LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

**Line 7**--Enter the total charges that relate to the reasonable cost on line 6 from Worksheet D, Part V, columns 4 and 4.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

**NOTE:** If the amounts on Worksheet D, Part V, include charges for professional services, eliminate the amount of the professional component from the charges entered on line 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of customary charges over reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 13--Enter the excess of reasonable cost over the customary charges. If line 6 exceeds line 11, enter the difference.

Line 14--Enter the lesser of the reasonable cost on line 6 or the customary charges on line 11.

**NOTE:** If these services are exempt from LCC, enter the reasonable costs from line 6.

Line 15--Enter, in column 1, the Part B deductibles and the Part B coinsurance billed to Medicare beneficiaries. DO NOT INCLUDE deductibles or coinsurance billed to program patients for physicians' professional services. If a hospital bills beneficiaries a discounted amount for the service or procedure, coinsurance entered on line 15 reflects coinsurance based on 20 percent of full charges, not discounted charges.

**NOTE:** If these services are exempt from LCC, enter the Part B deductibles from line 3. Exclude Part B coinsurance.

Line 16--Subtract line 15 from line 14 for column 1. Enter the amount on line 14 for column 1.01.

**NOTE:** If these services are exempt from LCC, subtract the deductible on line 15 from line 14, and multiply the result by 80 percent.

Line 17--Enter 50 percent of line 16 for columns 1 and 1.01.

Line 18--Enter the sum of lines 5 and 17.

Line 19--Enter the lesser of lines 16 or 18 in column 1 and 1.01.

Line 20--Enter the Part B deductibles and coinsurance in column 1.01 only.

Line 21--In column 1 enter the amount reported on line 19. In column 1.01 subtract line 20 from line 19. If these services are exempt from LCC, subtract the deductible on line 20 from line 19, and multiply the result by 80 percent. Transfer the sum of columns 1 and 1.01 for title XVIII, to Worksheet E, Part B, line 20; and for titles V and XIX to Worksheet E-3, Part III, column 1, line 37.

**3631. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**

Complete this worksheet for each component of the health care complex which has a separate provider or subprovider number as shown on Worksheet S-2. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. When the worksheet is completed for a component, show both the hospital provider number and the component number. Complete this worksheet for only Medicare interim payments by the intermediary. Do not complete it for purposes of reporting interim payments for titles V or XIX or for reporting payments made under the composite rate for ESRD services. Providers paid on an interim basis on periodic interim payment (PIP) adjust the interim payments for MSP/LCC claims.

The following components use the indicated worksheet instead of Worksheet E-1:

- o Hospital-based HHAs use Worksheet H-8.
- o Hospital-based outpatient rehabilitation facilities use Worksheet J-4.

The column headings designate two categories of payments:

Columns 1 and 2 - Inpatient Part A  
Columns 3 and 4 - Part B

Complete lines 1 through 4. The remainder of the worksheet is completed by your intermediary. All amounts reported on this worksheet must be for services, the costs of which are included in this cost report.

**NOTE:** When completing the heading, enter the provider number and the component number which corresponds to the provider, subprovider, SNF, or swing bed-SNF which you indicated.

DO NOT reduce any interim payments by recoveries as result of medical review adjustments where the recoveries were based on a sample percentage applied to the universe of claims reviewed and the PS&R was not also adjusted.

DO NOT include fee-schedule payments for ambulance services rendered on or after January 1, 2006.

### Line Descriptions

Line 1--Enter the total Medicare interim payments paid to you (excluding payments made under the composite rate for ESRD services), including amounts paid under PPS. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable. If you are reimbursed under the periodic interim payment method of reimbursement, enter the periodic interim payments received for this cost reporting period.

Line 2--Enter the total Medicare interim payments (excluding payments made under the ESRD composite rate) payable on individual bills.

Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period.

Also, include in column 4 the total Medicare payments payable for servicing home program renal dialysis equipment when the provider elected 100 percent cost reimbursement.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date

Line 4--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer as follows:

<u>Reimbursement Method</u>	<u>From Column</u>	<u>Transfer To</u>
Part B Payments	4	Wkst. E, Part B, line 34
<u>Part A Payments</u>		
PPS	2	Wkst. E, Part A, line 28
TEFRA	2	Wkst. E-3, Part I, line 19
Cost	2	Wkst. E-3, Part II, line 32

**NOTE:** For a swing bed-SNF, transfer the column 2, line 4, and column 4, line 4, amounts to Worksheet E-2, columns 1 and 2, line 20, respectively.

For SNFs reimbursed under PPS, transfer the amount in column 2, line 4, to Worksheet E-3, Part III, column 2, line 57.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.**

Line 5--List separately each settlement payment after the cost report is received together with the date of payment. If the cost report is reopened after the NPR has been issued, continue to report all settlement payments after the cost report is received separately on this line.

Line 6--Enter the net settlement amount (balance due the provider or balance due the program). Obtain the amounts as follows:

<u>Worksheet E-1, Column as Indicated</u>	<u>From Settlement Worksheet</u>
2	Wkst. E, Part A, line 29
4	Wkst. E, Part B, line 35
2	Wkst. E-3, Part I, line 20
2	Wkst. E-3, Part II, line 33

For swing bed-SNF services, column 2 must equal Worksheet E-2, column 1, line 21. Column 4 must equal Worksheet E-2, column 2, line 21.

For SNFs paid under PPS, column 2 must equal Worksheet E-3, Part III, column 2, line 58.

**NOTE:** On lines 3, 5, and 6, when a provider to program amount is due, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Line 7--Enter in columns 2 and 4 the sum of lines 4 through 6. Enter amounts due the program as a negative number. This amount must agree with amount due provider reported on Worksheet E, Part A, line 26, Worksheet E, Part B, line 32, Worksheet E-2, line 18, Worksheet E-3, Part I, line 17, Worksheet E-3, Part II, line 30, and Worksheet E-3, Part III, line 55.

3632. WORKSHEET E-2 - CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

This worksheet provides for the reimbursement calculation for swing bed services rendered to program patients under titles V, XVIII, and XIX. It provides for an accumulation of reimbursable costs determined on various worksheets within the cost report package. It also provides (under Part B) for the computation of the lesser of 80 percent of reasonable cost after deductibles or reasonable cost minus coinsurance and deductibles. These worksheets have been designed so that components must prepare a separate worksheet for swing bed-SNF title XVIII, Parts A and B, and separate worksheets for swing bed-NF for title V and title XIX. Use column 1 only on the worksheets for title V and title XIX. Indicate the use of each worksheet by checking the appropriate boxes. When a hospital with a certified SNF component has made an election to use the swing bed optional method for the SNF, the SNF component uses this worksheet to compute the swing bed-SNF reimbursement. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.5.B.)

Lines 1 through 9--Enter in the appropriate column on lines 1 through 7 the indicated costs for each component of the health care complex.

Line 1--Enter the cost of swing bed-SNF inpatient routine services transferred from Worksheet D-1, Part II, line 62 (title XVIII only). Effective for cost reporting periods beginning on or after July 1, 2002 swing beds are paid on the basis of SNF PPS and are required to input the total PPS payments in column 1 or 2, as applicable, from the provider's books and records or the PS&R. (See Vol. 67 FR 147 dated July 31, 2002 and PM A-02-016, change request 1666) However, for CAHs with reporting periods beginning on or after July 1, 2002, continue to transfer the amount from worksheet D-1, part II, line 62. CAHs with reporting periods beginning on or after January 1, 2004, transfer 101 percent of the amount from worksheet D-1, part II, line 62.

For RPCH providers, enter this amount from Worksheet C, Part IV, column 2, line 9. Make no entry on line 1 when Worksheet E-2 is used for swing bed-NF unless your State recognizes only SNF level of care. Then do not use lines designated as NF.

Do not use lines 2 and 3 for swing bed SNF PPS providers.

Line 2--Enter the cost of swing bed-NF inpatient routine services transferred from Worksheet D-1, Part II, line 65 (titles V and XIX only). For RPCH providers, enter this amount from Worksheet C, Part IV, columns 1 or 3, line 9, for titles V or XIX. Make no entry on line 2 when Worksheet E-2 is used for swing bed-SNF.

Line 3--Enter the amount of ancillary services (CAHs with reporting periods beginning on or after January 1, 2004, transfer for Title XVIII services 101 percent of the amounts from the applicable worksheets):

Title V	from	Worksheet D-4, col. 3, line 101
Title XVIII, Part A	from	Worksheet D-4, col. 3, line 101
Title XVIII, Part B	from	The sum of Worksheet D, Part V, cols. 9 and 11, line 104 and Worksheet D, Part VI, line 3
Title XIX	from	Worksheet D-4, col. 3, line 101

Enter title XVIII, Part B amounts only in column 2. Enter all other amounts in column 1.

Line 4--Enter (in column 1 for titles V and XIX and in column 2 for title XVIII) the per diem cost for interns and residents not in an approved teaching program transferred from Worksheet D-2, Part I, column 4, line 2 or line 10, as appropriate.

Line 5--For title XVIII, enter in column 1 the total number of days in which program swing bed-SNF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 10 and 11. For titles V or XIX, enter in column 1 the total number of days in which program swing bed-NF patients were inpatients. Transfer these days from Worksheet D-1, Part I, sum of lines 12 and 13. For title XVIII, enter in column 2 the total number of days in which Medicare swing bed beneficiaries were inpatients and had Medicare Part B coverage. Determine such days without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days.

The following reconciliation format is recommended:

Part A Inpatient Days	Plus	Part B Only Days	Minus	Part A Coverage But No Part B Days Coverage	Equals	Medicare Part B Days
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**NOTE:** See §3623.1.

Line 6--Enter the amount on line 4 multiplied by the number of days recorded on line 5. Also, if the hospital qualifies for the exception for graduate medical education payments in 42 CFR 413.86 (e)(4)(i), enter the amount transferred from Worksheet D-2, Part II, column 7, line 27.

Line 7--If Worksheet E-2 is completed for a certified SNF that has made an election to be reimbursed as though it were a swing bed hospital, enter the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees applicable to the SNF. (See 42 CFR 413.24(d)(5) and HCFA Pub. 15-I, §2230.5B.)

Line 8--Enter the sum of lines 1 through 3, plus lines 6 and 7 for each column.

Line 9--Enter any amounts paid and/or payable by workmens' compensation and other primary payers. (See instructions to Worksheet E, Part A, line 17, in §3630.1 for further clarification.)

Line 10--Line 8 minus line 9.

Line 11--Enter the deductible billed to program patients. **DO NOT INCLUDE** deductible applicable to physician professional services. Obtain this amount from your records.

Line 12--Enter line 10 minus line 11.

Line 13--Enter from your records the amounts billed to program patients for coinsurance. **DO NOT INCLUDE** coinsurance billed to program patients for physician professional services.

Line 14--In column 2, enter 80 percent of the amount on line 12.

Line 15--Enter the lesser of line 12 less line 13 or line 14.

Line 16--Enter any other adjustments. For example, enter an adjustment from changing the recording of vacation pay from cash basis to accrual basis, etc. (See HCFA Pub. 15-I, §2146.4.)

Line 17--When Worksheet E-2 is completed for Medicare, enter the amount of bad debts (net of bad debt recoveries) for billed deductibles and coinsurance (excluding bad debts for physician professional services) for Part A services in column 1 and for Part B services in column 2. If recoveries exceed the current year's bad debts, line 17 will be negative.

Line 17.01--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 17. (4/1/2004b)

Line 18--For title XVIII, Part A, enter in column 1 the sum of lines 15 and 17 plus or minus line 16. For title XVIII, Part B, enter in column 2 the sum of lines 15 and 17, plus or minus line 16. For titles V and XIX, enter in column 1 the sum of lines 15 and 17, plus or minus line 16.

Line 19--Enter the sequestration adjustment amount, if applicable.

Line 20--For title XVIII, enter in column 1 the amount from the appropriate Worksheet E-1, column 2, line 4, and enter in column 2 the amount from the appropriate Worksheet E-1, column 4, line 4. For intermediary final settlement, report on line 20.01 the amount from line 5.99 for columns 2 and 4. For titles V and XIX, enter interim payments from your records.

Line 21--Enter the amount recorded on line 18 minus the sum of the amounts on lines 19 and 20. This amount shows the balance due you or the program. Transfer this amount to Worksheet S, Part II, columns as appropriate, lines 3 or 4 for the swing bed-SNF or the swing bed-NF, respectively.

Line 22--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the supporting details and computations for this line.

## 3633. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

The five parts of Worksheet E-3 are used to calculate reimbursement settlement:

- Part I- Calculation of Medicare Reimbursement Settlement Under TEFRA, IRF PPS, LTCH PPS, and IPF PPS
- Part II- Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement (*CAHs*)
- Part III- Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services - Part A Services for Title XVIII PPS SNFs
- Part IV- Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs
- Part V- Calculation of NHC MQ Demonstration Reimbursement Settlement for Medicare Part A Services

3633.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA, IRF PPS, LTCH PPS, and IPF PPS.--Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA for hospitals and subproviders.

Use a separate copy of Worksheet E-3, Part I for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part I to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

#### Line Descriptions

Lines 1.01, 1.02, 1.05, and 1.06 pertain only to inpatient rehabilitation facilities (IRF) for cost reporting periods beginning on or after January 1, 2002 and long term care hospitals (LTCH) for cost reporting periods beginning on or after October 1, 2002. Line 1.03 and 1.04 pertain only to IRFs with cost reporting periods beginning on or after January 1, 2002. (See §1886(j) of the Act and PMs A-01-110 and A-01-131). Inpatient psychiatric facilities (IPF) complete lines 1, 1.01 and 1.08 through 1.23 for cost reporting periods beginning on or after January 1, 2005. Lines 1.08 through 1.23 are used exclusively for IPF services. (See Vol. 69, FR 219 dated November 15, 2004, page 66922 and CRs 3541 (December 1, 2004), 3678 (January 21, 2005), 3752 (March 4, 2005), and 3809 (April 29, 2005))

Line 1--Enter (for TEFRA hospitals, IRFs, and subprovider) the amount from Worksheet D-1, Part II, line 59. For IRFs, if Worksheet S-2, line 58, column 2 is yes, or for cost reporting period beginning on or after October 1, 2002, enter zero on this line. Enter for LTCHs with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006 the amount from Worksheet D-1, Part II, line 59.08. For LTCHs, if Worksheet S-2, line 59, column 2 is yes, or for cost reporting period beginning on or after October 1, 2006, enter zero on this line. Enter for IPFs with cost reporting periods beginning on or after January 1, 2005 and before January 1, 2008 the amount from Worksheet D-1, Part II, line 59. For IPFs, if Worksheet S-2, line 60, column 2 is yes, or for cost reporting period beginning on or after January 1, 2008, enter zero on this line.

Line 1.01--For IRFs enter hospital specific amount by multiplying line 1 times 33 1/3 percent. For LTCH enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (see 42 CFR §412.533(a)(1)) for the appropriate cost reporting period. For IPF enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (See 42 CFR §412.426(a)) for the appropriate cost reporting period.

Line 1.02--Enter the Net Federal IRF PPS for cost reporting periods beginning on or after January 1, 2002. The Federal payment includes short stay outlier amounts. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records. If line 1.01 is greater than zero, the PS&R will reflect 66 2/3 percent of the Federal IRF PPS payment amount (excluding LIP and outlier payments).

In accordance with The Federal Register, Vol. 70 FR 156 page 47933, dated August 15, 2005 and CR 4037 dated September 16, 2005, effective for IRF discharges rendered on or after October 1, 2005, it is necessary to subscript column 1 to identify the Net Federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2005 (column 1) and the Net Federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2005 (column 1.01) to appropriately prorate the LIP adjustment on line 1.04. Only subscript column 1 when the cost reporting period overlaps October 1, 2005, *except as otherwise indicated in the following paragraph*. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2005, *except as otherwise indicated in the following paragraph*.

*In accordance with the Federal Register, volume 74, number 151, page 39774, dated August 7, 2009, effective for IRF discharges rendered on or after October 1, 2009, subscript column 1 to identify the Net Federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2009 (column 1) and the Net Federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2009 (column 1.01) to appropriately prorate the LIP adjustment on line 1.04. Only subscript column 1 when the cost reporting period overlaps October 1, 2009. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2009.*

Enter the Net Federal LTCH PPS payment for cost reporting periods beginning on or after October 1, 2002, including short stay outlier payments. Obtain this information from the PS&R and/or your records. If line 1.01 is greater than zero, the PS&R will reflect the applicable reduced percent of the Federal IRF PPS payment amount (excluding short stay outlier payments). (See Vol. 67 FR 169 dated August 30, 2002, page 55976 for rates.)

Line 1.03--Enter the Medicare SSI ratio from your intermediary as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit). Not applicable for LTCH. (4/30/2003)

Line 1.04--IRF LIP payment, enter the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .4838 \text{ power} - 1\}$  times (line 1.02). L1 = IRF total Medicare Days from Worksheet S-3, Part I, column 4, lines 1 or 14 and subscripts as applicable (L1 is not applicable for T10 & subsequent transmittals). L2 = IRF Medicaid Days from Worksheet S-3, Part I, column 5, lines 1 or 14 and subscripts as applicable plus Medicaid HMO days (S-3, Part I, column 5, line 2 (subscript line 2 for IRF subproviders)). L3 = IRF total days from Worksheet S-3, Part I, column 6, lines 1 or 14 and subscripts as applicable plus employee discount days (S-3, Part I, column 6, line 28 (subscript line 28 for IRF subproviders)). Not applicable for LTCH.

In accordance with Vol. 70 FR 156 page 47933 dated August 15, 2005 and CR 4037 dated September 16, 2005, effective for discharges on or after October 1, 2005, the IRF LIP payment formula has been updated. For cost reporting periods that overlap October 1, 2005, column 1 must be subscripted. To calculate the IRF LIP payment for discharges prior to October 1, 2005, enter in column 1 the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .4838 \text{ power} - 1\}$  times (line 1.02, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2005, enter in column 1.01 the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .6229 \text{ power} - 1\}$  times (line 1.02, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2005, *except as otherwise noted*. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2005, enter in column 1 the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .6229 \text{ power} - 1\}$  times line 1.02. Not applicable for LTCH.

*In accordance with the Federal Register, volume 74, number 151, date August 7, 2009, page 39774, effective for discharges on or after October 1, 2009, the IRF LIP payment formula is updated. For cost reporting periods that overlap October 1, 2009, column 1 must be subscripted. To calculate the IRF LIP payment for discharges prior to October 1, 2009, enter in column 1 the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .6229 \text{ power} - 1\}$  times (line 1.02, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2009, enter in column 1.01 the result of  $\{(1 + (\text{line 1.03}) + (\text{L2/L3})) \text{ to the } .4613 \text{ power} - 1\}$  times (line 1.02, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after*

*October 1, 2009. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2009, enter in column 1 the result of  $\{(1 + (\text{line } 1.03) + (L2/L3)) \text{ to the } .4613^{\text{th}} \text{ power} - 1\}$  times line 1.02. Not applicable for LTCH.*

Line 1.05--Enter the IRF outlier payment. For LTCH enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

Line 1.06--Enter the sum of lines 1.01; 1.02, columns 1 and 1.01, as applicable; 1.04, columns 1 and 1.01, as applicable; *1.42, columns 1 and 1.01 as applicable*, and 1.05.

Line 1.07--Enter the amount of Nursing and Allied Health Managed Care payments if applicable. Only complete this line if your facility is a freestanding/independent non-PPS provider that does not complete Worksheet E, Part A.

Inpatient psychiatric facilities (IPF) complete lines 1, 1.01 and 1.08 through 1.23 for cost reporting periods beginning on or after January 1, 2005.

Inpatient Psychiatric Facility (IPF)-Lines 1.08 through 1.23

In accordance with the Federal Register (see Vol. 69, FR 219 dated November 15, 2004, page 66922) and Change Request 3541 (CMS Pub. 100-04, transmittal 384 dated December 1, 2004) and Change Request 3678 (CMS Pub. 100-04, transmittal 444 dated, January 21, 2005) complete these lines for IPFs effective for cost reporting periods beginning on or after January 1, 2005.

Line 1.08--Enter the net (blended) Federal IPF PPS payment for cost reporting periods beginning on or after January 1, 2005. This amount excludes payments for outliers, stop-loss, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 1.09--Enter the net (blended) IPF outlier payment. Obtain this from the PS&R and/or your records.

Line 1.10--Enter the net (blended) IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

**NOTE:** Complete only line 1.11 or line 1.12, but not both.

Line 1.11--For providers that trained residents **in the most recent cost reporting period filed before November 15, 2004** (response on Worksheet S-2, line 60.01, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period filed on or before November 15, 2004. See the above referenced Federal Register for a detailed explanation.

Line 1.12--For providers that did not train residents in the most recent cost reporting period filed before November 15, 2004, but qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to Worksheet S-2, line 60.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

Line 1.13--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program, then prorate the count accordingly.

Line 1.14--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program, then prorate the count accordingly.

Line 1.15--For providers that completed line 1.11, enter the lower of the FTE count on line 1.13 or the cap amount on line 1.11.

For providers that qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) during the first 3 program years of the first new program's existence, enter the FTE count from line 1.14.

Beginning with the 4<sup>th</sup> program year of the first new program's existence, enter the lower of the FTE count on line 1.13 or the FTE count on line 1.12. Add to this count the FTEs on line 1.14 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program.

Line 1.16--Enter the total IPF patient days divided by number of days in the cost reporting period (Worksheet S-3, column 6, line 1 (independent/freestanding) or 14 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 1.17--Enter the medical education adjustment factor by adding 1 to the ratio of line 1.15 to line 1.16. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 1.15} / \text{line 1.16})) \text{ to the } .5150 \text{ power} - 1\}$ .

Line 1.18--Enter the medical education adjustment by multiplying line 1.08 by line 1.17.

Line 1.19--Enter the adjusted net IPF PPS payments by entering the sum of lines 1.08, 1.09, 1.10, and 1.18.

Line 1.20--Enter the stop loss floor by entering the result of line 1 multiplied by 70 percent. For new IPFs (100 percent PPS) and for cost reporting periods beginning on or after January 1, 2008, enter zero (0) on this line.

Line 1.21--Enter the adjusted net payment floor by multiplying line 1.20 by the appropriate Federal blend payment percentage: (25 percent for cost reporting periods beginning on or after January 1, 2005 but prior to January 1, 2006, 50 percent for cost reporting periods beginning on or after January 1, 2006 but prior to January 1, 2007, or 75 percent for cost reporting periods beginning on or after January 1, 2007 but prior to January 1, 2008). Enter 100 percent if this is a new IPF (worksheet S-2, line 60, column 2 equals "Y") or for cost reporting periods beginning on or after January 1, 2008.

Line 1.22--If line 1.21 is greater than line 1.19 enter the amount on line 1.21 minus the amount on line 1.19; otherwise enter zero (0). This is the amount of the stop loss adjustment.

Line 1.23--Enter the IPF PPS payments by adding the amounts from lines 1.01, 1.19 and 1.22.

Inpatient Rehabilitation Facility (IRF)-Lines 1.35 through 1.42

In accordance with the Federal Register (see Vol. 70, No. 156, pages 47928-47932, dated August 15, 2005) and Change Request 4037 (CMS Pub. 100-04, transmittal 680 dated September 16, 2005), complete these lines for IRFs effective for discharges on or after October 1, 2005.

**NOTE:** Complete only line 1.35 or line 1.36, but not both.

**Line 1.35**--For providers that trained residents **in the most recent cost reporting period ending on or before November 15, 2004** (response to line 58.01, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period ending on or before November 15, 2004. See the above referenced Federal Register for a detailed explanation.

**Line 1.36**--For providers that did not train residents in the most recent cost reporting period ending on or before November 15, 2004, that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to line 58.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

**Line 1.37**--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program, then prorate the count accordingly.

**Line 1.38**--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program, then prorate the count accordingly.

**Line 1.39**--For providers that completed line 1.35, enter the lower of the FTE count on line 1.37 or the cap amount on line 1.35.

For providers that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005), during the first 3 program years of the first new program's existence enter the FTE count from line 1.38.

Beginning with the 4<sup>th</sup> program year of the first new program's existence, enter the lower of the FTE count on line 1.37 or the FTE count on line 1.36. Add to this count the FTEs on line 1.38 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4<sup>th</sup> program year of the first new program.

**Line 1.40**--Enter the total IPF patient days divided by number of days in the cost reporting period (Worksheet S-3, column 6, line 1 (independent/freestanding) or 14 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

**Line 1.41**--*For discharges prior to October 1, 2009, enter in column 1* the medical education adjustment factor by adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .9012 \text{ power} - 1\}$ .

*In accordance with the Federal Register, volume 74, number 151, date August 7, 2009, page 39774, effective for discharges on or after October 1, 2009, the medical education adjustment factor has been updated making it necessary to subscript column 1 for lines 1.41 and 1.42 for cost reporting periods that overlap October 1, 2009.*

*Calculate the medical education adjustment factor for discharges prior to October 1, 2009, by entering in column 1 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .9012$*

*power - 1}. To calculate the medical education adjustment factor for discharges on or after October 1, 2009, enter in column 1.01 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .6876 \text{ power} - 1\}$ . Do not subscript column 1 for lines 1.41 and 1.42 for cost reporting periods beginning on or after October 1, 2009.*

*Calculate the medical education adjustment factor for cost reporting periods beginning on or after October 1, 2009, by entering in column 1 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line 1.39} / \text{line 1.40})) \text{ to the } .6876 \text{ power} - 1\}$ .*

Line 1.42--Enter in *column 1*, the medical education adjustment by multiplying line 1.02, *column 1* by line 1.41, *column 1*. *If applicable, enter in column 1.01, the medical education adjustment by multiplying line 1.02, column 1.01 by line 1.41, column 1.01.* Add the *amounts in columns 1 and 1.01* to line 1.06.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-6, Part III, column 1, line 61 when Worksheet E-3, Part I, is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 2 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 3--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-9, Part II, column 3, line 16.

Line 4--Enter the sum of lines 1, 1.07, 2 and 3. IRFs/LTCH enter the sum of lines 1.06, 1.07, 2 and 3. IPFs enter the sum of lines 1.23, 2, and 3.

Line 5--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workmen's' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance. Include any primary payer amounts applied to Medicare beneficiaries coinsurance in situations where the primary payer payment does not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiary coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider.

Line 10--Enter the result of subtracting line 9 from line 8.

Line 11--Enter program reimbursable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 11 and 11.01 will be negative.

Line 11.01--Multiply the amount (including negative amounts) from Line 11 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; and 70 percent for October 1, 2000 and all subsequent periods.

Line 11.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11. (4/1/2004b)

Line 12--Enter the sum of lines 10 and 11.01.

Line 13--Enter the amount from Worksheet E-3, Part IV, line 24 for the hospital component only.

Line 13.01--For IRF cost reporting periods beginning on or after January 1, 2002, LTCH cost reporting periods beginning on or after October 1, 2002, and IPF cost reporting periods beginning on or after January 1, 2005, enter the routine service other pass through costs from Worksheet D, Part III, column 8, line 25 for a freestanding facility or line 31 for the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For IRFs, LTCHs, or IPFs reimbursed on a blended TEFRA rate percentage (worksheet S-2, line 58, 59, or 60, respectively, column 2 equals "N") reduce the pass through amounts by the TEFRA blend percentage used on line 1.01 for IRFs, IPFs, and LTCHs, respectively. After the respective transition periods have elapsed do not reduce this line as these facilities are entitled to 100 percent of other pass through costs.

Line 14--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 15--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, sequestration, etc, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. FIs only complete line 15.99 by entering the sum of lines 51 and 53.

Line 16--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

Line 17--Enter the sum of lines 12, 13, and 13.01 plus or minus lines 15 and 16 minus line 14.

Line 18--Enter the sequestration adjustment amount, if applicable.

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlements, report on line 19.01 the amount on line 5.99.

Line 20--Enter line 17 minus the sum of lines 18 and 19. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 21--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART I. LINES 50 THROUGH 53 ARE FOR INTERMEDIARY USE ONLY.**

Line 50--Enter the original outlier amount from worksheet E-3, Part I, line 1.05 (IRF) or 1.09 (IPF).

Line 51--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7.)

Line 53--Enter the time value of money.

**NOTE:** If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

3633.2 Part II - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement.--Use Worksheet E-3, Part II, to calculate reimbursement settlement for Medicare Part A services furnished by hospitals, including rural primary care hospitals/critical access hospitals, subproviders, and skilled nursing facilities under cost reimbursement (i.e., neither PPS nor TEFRA).

For cost reporting periods beginning on or after July 1, 1998, SNFs will not complete this form. Use a separate copy of Worksheet E-3 for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3 to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Line 1--Enter the appropriate inpatient operating costs:

Hospital (CAH) or Subprovider - Worksheet D-1, Part II, line 49

Skilled Nursing Facility - Worksheet D-1, Part III, line 82

RPCH - Worksheet C, Part IV, line 6 (Not applicable for cost reporting periods beginning after October 1, 1997)

Line 1.01--Enter the amount of Nursing and Allied Health Managed Care payments if applicable. Only complete this line if your facility is a freestanding/ independent non-PPS provider or CAH that does not complete Worksheet E, Part A.

Line 2--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 1, line 61 when this worksheet is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 2 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 3--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter amounts from Worksheet D-9, Part II, column 3, line 16.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full.

This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but not in program patient days and charges. In this situation, enter no primary payer payment on line 5. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system. However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--Enter the amount on line 4 minus the amount on line 5. For CAHs with cost reporting periods beginning on or after January 1, 2004, enter on this line 101 percent of the line 4 minus line 5. (1/1/20004b)

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e). An RPCH/CAH is not subject to this provision for inpatient services.

Line Descriptions

**NOTE:** An RPCH/CAH does not complete lines 7 through 17.

Lines 7 through 17--These lines provide for the accumulation of charges which relate to the reasonable cost on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §§2570-2577.

Line 7--Enter the program inpatient routine service charges from your records for the applicable component. Include charges for both routine and special care units. The amounts entered include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 8--Enter the total charges for inpatient ancillary services from Worksheet D-4, column 2, sum of lines 37 through 68.

**NOTE:** If the amounts on Worksheet D-4 include charges for professional services, eliminate the amount of the professional component from the charges entered on line 11. Submit a schedule showing these computations with the cost report.

Line 9--When Worksheet E-3 is completed for a CTC hospital component, enter the organ acquisition charges from Worksheet D-6, Part III, line 61, column 3.

Line 10--Enter your charges for the services for which the cost is entered on line 3.

Line 11--Enter the sum of lines 7 through 10.

Lines 12 through 15--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or when you fail to make reasonable efforts to collect such charges from those patients. If line 14 is greater than zero, multiply line 11 by line 14, and enter the result on line 15. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 12 through 14. Enter on line 15 the amount from line 11. In no instance may the customary charges on line 15 exceed the actual charges on line 11. (See 42 CFR 413.13(e).)

Line 16--Enter the excess of the customary charges on line 15 over the reasonable cost on line 6.

Line 17--Enter the excess of reasonable cost on line 6 over the customary charges on line 15. Transfer line 17 to line 21.

#### Computation of Reimbursement Settlement

Line 18--Enter the amount from Worksheet E-3, Part IV, line 24. Complete for the hospital component only.

Line 19--Enter the sum of lines 6 and 18.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21--Enter the amount, if any, recorded on line 17. If you are a nominal charge provider, enter zero.

Line 22--Enter line 19 less the sum of lines 20 and 21.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter from your records program reimbursable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 25.01 will be negative.

Line 25.01--Multiply the amount (including negative amounts) on Line 25 by 100 percent for cost reporting periods beginning on or after October 1, 1996, 75 percent for October 1, 1997, 60 percent for October 1, 1998 and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and all subsequent periods. No reduction is required for critical access hospitals.

Line 25.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 25. (4/1/2004b)

Line 26--Enter the sum of lines 24 and 25 or 25.01 (hospitals and subproviders only).

Line 27--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 28--Enter any other adjustments. For example, if you change the recording of vacation pay from cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

For SNFs only, include the title XVIII portion of the amount of the State's bill for determining the validity of nurse aide training and testing under §4211(b)(5) of P.L. 100-203. This adjustment includes the State's cost of deeming individuals to have completed training and testing requirements and the State's cost of determining the competency of individuals trained by or in a facility based program.

Line 29--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

Line 30--Enter line 26, plus or minus lines 28 and 29, minus line 27.

Line 31--Enter the sequestration adjustment amount, if applicable.

Line 32--Enter interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlement, report on line 32.01 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines 31 and 32. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 34--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

3633.3 Part III - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services and Part A Services for Title XVIII PPS SNFs.--Worksheet E-3 calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs. For titles V and XIX, complete column 1. For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services using column 2. For Part B services, all SNFs complete Worksheet E, Part B.

Use a separate copy of this part for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of this part to indicate the component and program for which it is used. When this part is completed for a component, show both the hospital and component numbers. Enter check marks in the appropriate spaces to indicate the applicable reimbursement method for inpatient services (e.g., PPS, TEFRA, OTHER).

If the State program is under PPS for inpatient hospital services, do not complete line 1. Complete lines 24 through 32 for services covered by PPS. Complete lines 2 through 8, 9 through 15, and 16 through 23 only for services not covered by PPS. If the State program follows TEFRA for inpatient hospital services, do not complete lines 24 through 29. If the State program follows cost reimbursement, do not complete lines 15 and 24 through 29.

Computation of Net Costs of Covered ServicesLine Descriptions

Line 1--Enter the appropriate inpatient operating costs.

Cost Reimbursement

Hospital/CAH or Subprovider - Worksheet D-1, Part II, line 49  
 Skilled Nursing Facility, Other Nursing Facility, ICF/MR - Worksheet D-1, Part III, line 82. If Worksheet S-2, line 38.03 is answered yes, and multiple Worksheets D-1 are prepared, add the multiple Worksheets D-1 and enter the result. For cost reporting periods beginning on or after July 1, 1998 make no entry.  
 RPCH - Worksheet C, Part IV, line 6

TEFRA

Hospital or Subprovider - Worksheet D-1, Part II, line 59

**NOTE:** If you are a new provider reimbursed under TEFRA, use Worksheet D-1, Part II, line 49.

Line 2--Enter in column 1 the cost of outpatient services for titles V or XIX which is the sum of Worksheet D, Part V, column 9 and subscripts where applicable (SNFs only) (hospitals use column 9 and subscripts where applicable), line 104 and Worksheet D, Part VI, line 3 and subscripts where applicable. For RPCHs, enter the sum of Worksheet C, Part V, lines 107 or 109, and Worksheet D, Part VI, line 3. For title XVIII, enter in column 2 the amount from Worksheet D-4, column 3, line 101. For SNFs participating in the demonstration, enter the amount from Worksheet E-3, Part V, line 5. For cost reporting periods beginning on or after July 1, 1998 make no entry for Title XVIII.

Line 3--Enter in column 1 for titles V or XIX the cost of services rendered by interns and residents as follows from Worksheet D-2

	<u>Title V</u>	<u>Title XIX</u>
Hospital	Part I, col. 8, line 9 plus line 24	Part I, col. 10, line 9 plus line 24
Subprovider	Part I, col. 8, line 10	Part I, col. 10, line 10
Nursing Facility, ICF/MR	Part I, col. 8, line 13	Part I, col. 10, line 13

Line 4--For titles V and XIX, enter in column 1 the amount paid or payable by the State program for organ acquisition.

Line 5--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter in column 1 amounts from Worksheet D-9, Part II, column 3.

<u>Title V</u>	<u>Title XIX</u>
Sum of lines 14 and 15	Sum of lines 18 and 19

Line 6--Enter the sum of lines 1 through 5.

Line 7--Enter the amounts paid or payable by workmens' compensation and other primary payers where program liability is secondary to that of the primary payer for inpatient services. For title XVIII SNFs reimbursed under PPS, enter in column 2 only the primary payer amounts applicable to Part A routine and ancillary services

Line 8--Enter in column 1 the primary payer amounts applicable to outpatient services for titles V and XIX.

Line 9--Enter line 6 minus the sum of lines 7 and 8.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or your customary charges for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e). RPCH components must follow State instructions regarding the application of LCC to determine the applicability of this provision. This section is not required for SNFs with cost reporting periods beginning on or after July 1, 1998.

#### Line Descriptions

Lines 10 through 15--These lines provide for the accumulation of charges which relate to the reasonable cost on line 9.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §§2570-2577.

Line 10--Enter in column 1 the program inpatient routine service charges from your records for the applicable component for titles V and XIX. This includes charges for both routine and special care units.

The amounts entered on line 10 include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 11--For titles V and XIX, enter in column 1 the sum of the appropriate program ancillary charges from Worksheet D, Part V, column 5 plus subscripts as applicable, line 104; Worksheet D, Part VI, line 2; and Worksheet D-4, column 2, line 103.

For title XVIII SNFs reimbursed under PPS (less than 1500 days), for cost reporting periods beginning prior to July 1, 1998, enter in column 2 the amount from Worksheet D-4, column 2, line 103; otherwise make no entry.

Line 12--Enter in column 1 (for titles V or XIX) the total billed charges from your records for services of interns and residents furnished to program beneficiaries.

Line 13--Enter in column 1 (for titles V and XIX) the organ acquisition charges from line 4.

Line 14--Enter in column 1 (for titles V or XIX) your charges for the services for which the cost is entered on line 5.

Line 15--Enter in column 1 (for titles V and XIX) the amount of the incentive resulting from the target amount computation on Worksheet D-1, Part II, line 58, if applicable.

Line 16--Enter the sum of the amounts recorded on lines 10 through 15.

Lines 17 through 20--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 19 is greater than zero, multiply line 16 by line 19, and enter the result on line 20. If you do impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 17 through 19. Enter on line 20 the amount from line 16. In no instance may the customary charges on line 20 exceed the actual charges on line 16. For title XVIII SNFs reimbursed under PPS, lines 18 through 20 apply to Part A ancillary services only. For SNFs for cost reporting periods beginning on or after July 1, 1998, no entry is required.

Line 21--Enter the excess of the customary charges over the reasonable cost. If the amount on line 20 is greater than the amount on line 9, enter the excess.

Line 22--Enter the excess of total reasonable cost over the total customary charges. If the amount on line 9 exceeds the amount on line 20, enter the excess. Transfer this amount to line 34.

Line 23--Enter in columns 1 and 2 the amount from line 9.

#### Prospective Payment Amount

Line 24--Compute in column 1 the sum of the following amounts supplied by the intermediary:

- o The DRG payments made for PPS discharges during the cost reporting period, and
- o The DRG payments made for PPS transfers during the cost reporting period.

For Title XVIII SNFs reimbursed under PPS (less than 1500 days), multiply the number of Medicare days by the prospective payment rate, and enter the result in column 2. If the SNF is participating in the demonstration, transfer the amount reported on Worksheet E-3, Part V, line 25. For cost reporting periods beginning on or after July 1, 1998, transfer the amount from Worksheet S-7, column 5, line 46. SNFs electing 100 percent Federal rate for cost reporting periods beginning on or after July 1, 2001, providers are required to input the total RUG payments. Obtain this from your books and records or the PS&R.

Line 25--Enter in column 1 the amount of outlier payments made for PPS discharges during the period. See CMS Pub. 15-I, chapter 28 for a discussion of these outlier payments.

Line 26--Enter in column 1 the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 27--Enter the amount from Worksheet L, Part IV, line 13, as applicable for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

Line 28--Enter the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 and 33 for hospital or from line 31 for the subprovider. For cost reporting periods beginning on or after July 1, 1998, for title XVIII SNFs, enter in column 2 the amount from Worksheet D, Part III, column 8, line 34.

Line 29--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For cost reporting periods beginning on or after July 1, 1998, for title XVIII SNFs, enter the amount from Worksheet D, Part IV, column 7, line 101.

Line 30--Enter the sum of lines 23 through 29.

Line 31--For titles V and XIX only, enter the customary charges for PPS.

Line 32--For titles V and XIX PPS, enter the lesser of lines 30 or 31. For non PPS, enter the amount from line 30. For title XVIII, enter the amount from line 30.

Line 33--Enter any deductible amounts imposed.

#### Computation of Reimbursement Settlement

Line 34--Enter the amount, if any, from line 22. For SNFs with cost reporting periods beginning on or after July 1, 1998, do not complete this line.

Line 35--Enter line 32 less the sum of lines 33 and 34.

Line 36--Enter any coinsurance amounts.

Line 37--For titles V and XIX, enter in column 1 the sum of the amounts from line 19 of Worksheet E, Parts C, D, and E. Do not complete this line for title XVIII.

Line 38--Enter from your records program reimbursable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, lines 38 (Title XVIII SNFPPS, V or XIX) and 38.01 (Title V or XIX) will be negative. Reimbursable bad debts for hospital-based PPS SNFs under title XVIII are paid at 100 percent for cost reporting periods beginning prior to October 1, 2005.

Line 38.01, column 1--Applies to hospitals and subproviders only if Title V or XIX follow Medicare principles--Multiply the amount (including negative amounts) on line 38 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; 70 percent for October 1, 2000 and all subsequent periods.

Line 38.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 38. (4/1/2004b)

Line 38.03--DRA 2005 SNF Bad Debt--For cost reporting periods beginning on or after October 1, 2005 calculate this line as follows:  $[(\text{line 38} - \text{line 38.02}) * .7] + \text{line 38.02}$ . This is the adjusted SNF allowable bad debt in accordance with DRA 2005, section 5004. (10/1/2005b)

Line 39--Enter the title XVIII reasonable compensation paid to physicians for services on utilization review committees to an SNF. Include the amount on this line in the amount eliminated from total costs on Worksheet A-8. Transfer this amount from Worksheet D-1, line 81.

Line 40--For cost reporting periods beginning prior to October 1, 2005, enter the sum of lines 35, 37, 38 (Title XVIII, column 2) or 38.01 (Title V or XIX, column 1) and 39, minus line 36. For cost reporting periods beginning on or after October 1, 2005, enter the sum of lines 35, 37, 38.01 (Title V or XIX, column 1) or 38.03 (Title XVIII, column 2) and 39, minus line 36.

Lines 41 through 48--Do not complete these lines.

Line 49--Enter in column 1, for titles V and XIX, and in column 2, for title XVIII SNFs reimbursed under PPS, the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination of a decrease in program utilization.

**NOTE:** For titles V or XIX PPS providers for whom capital is included in PPS, the prior periods are only those paid under reasonable cost or the hold harmless methodology under capital PPS.

Line 50--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to the accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

Line 51--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. Enter the amount of any excess depreciation taken as a negative amount.

**NOTE:** For titles V or XIX PPS providers for whom capital is included in the PPS, the prior periods are only those paid under reasonable cost or the hold harmless methodology under capital PPS.

Line 52--Enter the result of line 40, plus or minus lines 50 and 51, minus line 49.

Line 53--For provider components subject to PPS under titles V and XIX only, enter the amount of the additional payment amounts relating to indirect medical education.

Line 54--Enter the amount from Worksheet E-3, Part IV, line 23 or line 23.01

Line 55--Enter the sum of lines 52, 53, and 54.

Line 56--Enter the sequestration adjustment amount, if applicable.

Line 57--For titles V and XIX, obtain interim payments from your records. For title XVIII, enter the total interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlement, report on line 57.01 the amount from line 5.99.

Line 58--Enter line 55 minus the sum of the amounts on lines 56 and 57. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 59--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

**3633.4 Part IV - Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs.**--Use this worksheet to calculate each program's payment (i.e., titles XVIII, V, and XIX) for direct graduate medical education (GME) costs as determined under 42 CFR 413.83. This worksheet applies to the direct graduate medical education cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers. Complete this worksheet if the response to line 25.01 of Worksheet S-2 is "Y". The direct medical education costs of the nursing school and paramedical education programs continue to be paid on a reasonable cost basis as determined under 42 CFR 413.85. However, the nursing school and paramedical education costs, formerly paid through the ESRD composite rate as an exception, are paid on this worksheet on the basis of reasonable cost under 42 CFR 413.85. Effective for cost reporting periods beginning on or after October 1, 1997 the unweighted direct medical education FTE is limited to the hospital's FTE count for the most recent cost reporting period ending on or before December 31, 1996. This limit applies to allopathic and osteopathic residents but excludes dentistry and podiatry. The GME payment is also based on the inclusion of Medicare HMO patients treated in the hospital beginning for services rendered on or after January 1, 1998. The percent of Medicare HMO patient days that is included is limited to 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent by 2002. For cost reporting periods beginning before October 1, 1997, complete lines 1 through 3. For cost reporting periods beginning on or after October 1, 1997 skip lines 1 through 3 and begin with line 3.01.

**NOTE:** Do not complete this worksheet for GME if residents were on duty only after the first month of the cost reporting period. These costs are reimbursed as a reasonable cost and as such are not reimbursed through this worksheet. (See 42 CFR 413.86(e)(4).)

Complete this worksheet if this is the first month in which residents were on duty during the first month of the cost reporting period or if residents were on duty during the entire prior cost reporting

period. (See 42 CFR 413.86(e)(4).)

This worksheet consists of five sections:

1. Computation of Total Direct GME Amount
2. Computation of Program Patient Load
3. Direct Medical Education Costs for ESRD Composite Rate - Title XVIII only
4. Apportionment of Medicare Reasonable Cost (title XVIII only)
5. Allocation of Medicare Direct GME Costs Between Part A and Part B

Computation of Total Direct GME Amount.--This section computes the total approved amount.

#### Line Descriptions

Lines 1 and 1.01--Enter the total number of FTE residents. Compute this amount in accordance with 42 CFR 413.86(f), (g), and (h).

**NOTE:** If this is a short period cost report, FTEs are prorated by the ratio of the number of days in the cost reporting period to the number of days in the calendar year.

Lines 2 and 2.01--Enter the updated per resident amount obtained from the intermediary in conformance with the subscribing on line 1.

In accordance with 42 CFR 413.86(e), if this is the first cost reporting period in which residents were on duty during the first month of the cost reporting period, enter the per resident amount based on the lower of:

o The sum of Worksheet B, Part I, columns 22 and 23, line 103 divided by the number of FTEs reported on line 1; or

o The weighted mean value of per resident amounts of hospitals located in the same geographic wage area for cost reporting periods beginning in the same fiscal year. Obtain this amount from your fiscal intermediary.

Line 3--Multiply the number of FTE residents on lines 1 and 1.01 by the updated amount on lines 2 and 2.01, and enter the result in the aggregate on line 3. Round to the whole number during each phase of this computation.

FTE residents subject to the cap for cost reporting periods beginning on or after October 1, 1997:

Line 3.01--Enter the unweighted resident FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before December 31, 1996. If this cost report is less than a full 12 months, contact your intermediary.(42 CFR 413.86(g)(4). Also include here the 30 percent increase to the count for qualified rural hospitals (42 CFR 413.86(g)(4)(i)), and the increase due to primary care residents that were on approved leaves of absence (42 CFR 413.86(g)(9).(4/01) Effective for cost reporting periods beginning on or after October 1, 2001, temporarily reduce the FTE count of a hospital that closed a program(s), if the regulations at 42 CFR 413.86(g)(9)(iii)(B) are applicable.

Line 3.02--Enter the unweighted resident FTE count for allopathic and osteopathic programs which meet the criteria for an adjustment to the cap for new programs in accordance with 42 CFR 413.86(g)(6). For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(i), the cap is effective beginning with the fourth program year of the first new program accredited or begun on or after January 1, 1995. For hospitals qualifying for a cap adjustment under 42 CFR 413.86(g)(6)(ii), the cap for each new program accredited or begun on or after January 1, 1995 and

before August 6, 1997, is effective in the fourth program year of each of those new programs (see 66 FR August 1, 2001, 39881). The cap adjustment reported on this line should not include any resident FTEs that were already included in the cap on line 3.01. Also enter the unweighted allopathic or osteopathic FTE count for residents in all years of the rural track program that meet the criteria for an add-on to the cap under 42 CFR 413.79(j). If the rural track program is a new program under 42 CFR 413.79(l) and qualifies for a cap adjustment under 413.79(e)(1) or (e)(3), do not report FTE residents in the rural track program on this line until the fourth program year of the rural track program. Report these FTEs on line 3.16 or line 3.22 (04/01). Also include here any temporary adjustment to the cap due to a hospital closing effective for cost reporting periods beginning before October 1, 2001.

Line 3.03--Enter the adjustment (increase or decrease) for the unweighted resident FTE count for allopathic or osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), and (63 FR 26 336 May 12, 1998).

Line 3.04--Enter the sum of lines 3.01 through 3.03, which is the FTE adjusted cap. For cost reporting periods ending on or after July 1, 2005, if worksheet S-2, line 25.05, column 1 is "N", enter the sum of lines 3.01 through 3.03. If this hospital's FTE cap is reduced under 42 CFR §413.79(c)(3) due to unused resident slots, (Worksheet S-2, line 25.05, column 1 is "Y"), effective for cost reporting periods ending on or after July 1, 2005, enter the sum of line 3.03 and line 4 from Worksheet E-3, Part VI.

Line 3.05--Enter the unweighted resident FTE count for allopathic or osteopathic programs for the current year from your records, other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. (42 CFR 413.79(d) and/or (e)).

Line 3.06--Enter the lesser of lines 3.04 or 3.05.

Line 3.07--Enter the weighted FTE count for primary care physicians and OB/GYN residents in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero. (42 CFR 413.79(d) and/or (e)).

Line 3.08--Enter the weighted FTE count for all other physicians in an allopathic or osteopathic program for the current year other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero. (42 CFR 413.79(d) and/or (e) (10/97)).

Line 3.09--Enter the sum of lines 3.07 and 3.08.

Line 3.10--For cost reporting periods beginning prior to October 1, 2001, if line 3.05 is less than or equal to line 3.04, enter the amount from line 3.09, otherwise multiply line 3.09 by  $(3.04/\text{line } 3.05)$ . (10/97) For cost reporting periods beginning on or after October 1, 2001, if line 3.05 is less than or equal to line 3.04, enter the amount from line 3.09, otherwise multiply line 3.07 by  $(\text{line } 3.04/\text{line } 3.05)$  and multiply line 3.08 by  $(\text{line } 3.04/\text{line } 3.05)$  and add the results. (42 CFR 413.79(c)(2)(iii)).

Line 3.11--Enter the weighted dental and podiatric resident FTE count for the current year. For cost reporting periods beginning prior to October 1, 2001, if the count has been reduced to zero subscript the column and enter the count from the previous year in column zero (10/97).

Line 3.12--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.10 and 3.11 for column 1 or column 0, if applicable. For cost reporting periods beginning on or after October 1, 2001, if the amount from line 3.09 is reported on line 3.10 enter the sum of lines 3.11 and 3.08. Otherwise, enter the sum of line 3.11 and  $(3.08 \text{ times } (\text{line } 3.04/\text{line } 3.05))$ .

Line 3.13--For cost reporting periods beginning prior to October 1, 2001, enter the total weighted FTE resident count for the prior cost reporting year (if subject to the cap in the prior year, report the sum of lines 3.10 and 3.11 of the prior year), other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules. If a zero is entered on this line, enter in column zero a 1 if the hospital did not report FTEs this period, but did have an approved program. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE count for nonprimary care residents for the prior year (if subject to the cap in the prior year, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11, other than those in the initial years of the program that meet the criteria for an exception to the averaging rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific nonprimary program included in line 3.16 of the prior year's cost report.

Line 3.14--For cost reporting periods beginning on or after October 1, 1998, but prior to October 1, 2001, enter the total weighted FTE resident count for the cost reporting year before last (if subject to the cap in the year before last, report the sum of lines 3.10 and 3.11 of the year before last) other than those in the initial years of the program that meet the exception to the averaging rules. If zero is entered on this line, enter in column zero a 1 if the hospital did not report FTEs but did have an approved program. For cost reporting periods beginning on or after October 1, 2001, enter the total weighted FTE resident count for nonprimary care residents for the cost reporting year before last (if subject to the cap in the year before last, report the result of line 3.08 times (line 3.04/line 3.05) plus line 3.11 other than those in the initial years of the program that meet the criteria for an exception to the rolling average rules (42 CFR 413.79(d)(5)). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific nonprimary program from line 3.16 of the penultimate year's cost report.

Line 3.15--For cost reporting periods ending prior to June 30, 2006, enter the rolling average FTE count by adding lines 3.12 through 3.14 and divide by the number of lines greater than zero (see 42 CFR 413.79(d)(5)) unless column zero is completed for any of these lines. For cost reporting periods ending on or after June 30, 2006, enter the rolling average FTE count by adding lines 3.12 through 3.14 and divide by 3.

Line 3.16--For cost reporting periods beginning prior to October 1, 2001, enter the weighted number of FTE residents in the initial years of a primary care and OB/GYN program that meets the exception to the rolling average rules. For cost reporting periods beginning on or after October 1, 2001, enter the sum of line 3.15 and the weighted number of nonprimary care FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.79(d)(5) and/or 413.79(e). Effective for cost reporting periods beginning on or after October 1, 2001, also add the temporary weighted adjustments for nonprimary care FTE residents that were displaced by program or hospital closure. (42 CFR 413.79(h)).

For cost reporting periods ending on or after June 30, 2006, enter in column zero the weighted number of nonprimary care FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.79(d)(5) and/or 413.79(e)) and add the temporary weighted adjustments for nonprimary care FTE residents that were displaced by program or hospital closure. Enter in column 1 the sum of lines 3.15 and the number reported in column zero of this line.

Line 3.17--For cost reporting periods beginning prior to October 1, 2001, enter the weighted number of FTE residents in the initial years of all other programs that meet the rolling average exception criteria in 42 CFR 413.79(d). For cost reporting periods beginning on or after October 1, 2001 enter the nonprimary care per resident amount.

Line 3.18--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.15 through 3.17. For cost reporting periods beginning on or after October 1, 2001, enter the result of multiplying lines 3.16 times line 3.17.

Line 3.19--For cost reporting periods beginning prior to October 1, 2001, enter the primary care and OB/GYN physician per resident amount. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE resident count for primary care and OB/GYN residents for the prior year cost report (if subject to the cap in the prior year, report the result of line 3.07 times (line 3.04/line 3.05)) other than those in the initial years of the program that meet the criteria for an exception to the averaging rules 42 CFR 413.79(d)(5). However, if the period of years during which the FTE residents in any of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific primary program included in line 3.22 of the prior year's cost report.

Line 3.20--For cost reporting periods beginning prior to October 1, 2001, enter the all other program per resident amount. For cost reporting periods beginning on or after October 1, 2001, enter the weighted FTE resident count for primary care and OB/GYN residents in the cost reporting year before last (if subject to the cap in the year before last, report the product of line 3.07 times (line 3.04/line 3.05) from the year before last), other than those in the initial years of the program that meet the criteria for the rolling average exception. 42 CFR 413.79(d)(5). However, if the period of years during which the FTE residents in any year of your new training programs were exempted from the rolling average (see 42 CFR 413.79(d)(5) expired, also enter on this line the count of FTE residents in that specific primary program included in line 3.22 of the penultimate year's cost report.

For cost reporting periods beginning prior to October 1, 2001, in order to generate a weighted payment amount for lines 3.21 and 3.22, if lines 3.07 and/or 3.08 of column 1 are zero substitute the count for lines 3.07 and/or 3.08 for the current period with the counts entered in column zero for those lines. (10/01) For cost reporting periods beginning on or after October 1, 2001 this instruction no longer applies (10/01).

Line 3.21--For cost reporting periods beginning prior to October 1, 2001, enter the primary care unadjusted approved amount by multiplying the sum of lines 3.07 and 3.16 by line 3.19. For cost reporting periods beginning on or after October 1, 2001, if the amount from line 3.09 was reported on line 3.10, enter the rolling average primary care and OB/GYN count by adding the sum of (lines 3.07, 3.19 and 3.20)/3, otherwise, calculate the rolling average for primary care and OB/GYN FTE count as follows (line 3.07 times (line 3.04/line 3.05)), plus line 3.19, and 3.20) and divide the result by 3.

Line 3.22--For cost reporting periods beginning prior to October 1, 2001, enter the other unadjusted approved amount by multiplying line 3.20 by the sum of lines 3.08, 3.11, and 3.17. For cost reporting periods beginning on or after October 1, 2001 enter the sum of line 3.21 and the weighted number of primary care and OB/GYN FTE residents in the initial years of new allopathic and osteopathic programs 42 CFR 413.79(d)(5) and/or 413.79(e). Effective for cost reporting periods beginning on or after October 1, 2001, also add any temporary weighted adjustments for primary care and OB/GYN FTE residents that were displaced by program or hospital closure. 42 CFR 413.79(h).

For cost reporting periods ending on or after June 30, 2006, enter in column zero the weighted number of primary care OB/GYN FTE residents in the initial years of new allopathic and osteopathic programs (42 CFR 413.79(d)(5) and/or 413.79(e)) and add the temporary weighted adjustments for primary care and OB/GYN FTE residents that were displaced by program or hospital closure. Enter in column 1 the sum of lines 3.21 and the number reported in column zero of this line.

Line 3.23--For cost reporting periods beginning prior to October 1, 2001, enter the sum of lines 3.21 and 3.22. For cost reporting periods beginning on or after October 1, 2001 enter the primary care and OB/GYN per resident amount.

Line 3.24--For cost reporting periods beginning prior to October 1, 2001, divide line 3.23 by the sum of lines 3.07, 3.08, 3.11, 3.16, and 3.17. For cost reporting periods beginning on or after October 1, 2001 multiply line 3.23 by 3.22 and enter the result.

Line 3.25--For cost reporting periods beginning prior to October 1, 2001, enter the total approved amount for resident costs, line 3.24 times line 3.18. For cost reporting periods beginning on or after October 1, 2001 enter the sum of lines 3.18 and 3.24.

Computation of Program Patient Load - Non Managed Care--This section computes the ratio of program inpatient days to the total inpatient days. For this calculation, total inpatient days include inpatient days of the hospital along with its subproviders, including distinct part units excluded from the prospective payment system. Record hospital inpatient days of Medicare beneficiaries whose stays are paid by risk basis HMOs and organ acquisition days as non-Medicare days. Do not count inpatient days applicable to nursery, hospital-based SNFs and other nursing facilities, and other non-hospital level of care units for the purpose of determining the Medicare patient load.

#### Line Descriptions

Line 4--For title XVIII, enter the sum of the days reported on Worksheet S-3, Part I, column 4, lines 1, 6 through 10, and 14. For titles V or XIX, enter the amounts from columns 3 or 5, respectively, sum of lines 1, 6 through 10, and 14.

Line 5--Enter the sum of the days reported on Worksheet S-3, Part I, column 6, lines 1, 6 through 10, and 14 and subscripts as applicable.

Line 6--Divide line 4 by line 5 and enter the result (expressed as a decimal).

Lines 6.01 through 6.08 are completed for cost reports that end on or after January 1, 1998.

Line 6.01--Enter the total GME payment for non-managed care days. For 12 month cost reporting periods which end between January 1, 1998 and September 29, 1998, multiply line 6 times line 3. Otherwise multiply line 6 times line 3.25. (Including a short period cost report which begins on or after October 1, 1997 and ends prior to January 1, 1998.) For cost reporting periods that end on or after July 1, 2005, multiply line 6 times line 3.25 and to this amount, add the hospital's section 422 direct GME payment for non-managed care, from line 11 from Worksheet E-3, Part VI.

Computation of Program Patient Load - Managed Care Days--Effective January 1, 1998, hospitals will report managed care days to allow for a Medicare plus Choice direct GME payment 42 CFR 413.76(c).

Line 6.02--Enter Medicare managed care days occurring on or after January 1 of this cost reporting period. These days are included in the days reported on Worksheet S-3, Part I, column 4, line 2. The balance of the days prior to January 1 are entered on line 6.06. (4/30/03) Effective for cost reporting periods ending on after June 30, 2006, enter all Medicare managed care days on line 6.02.

Line 6.03--Enter total inpatient days from line 5 above.

Line 6.04--Enter the appropriate percentage for inclusion of the managed care days, beginning January 1 of each year, i.e. 20 percent for 1998, 40 percent for 1999, 60 percent for 2000, 80 percent for 2001, and 100 percent for 2002 and after.

Line 6.05--Calculate the Graduate Medical Education payment for managed care days on or after January 1 through the end of the cost reporting period, {(line 6.02/line 6.03) times (line 6.04)} times line 3, for cost reporting periods beginning before October 1, 1997, otherwise times line 3.25. For services rendered on or after January 1, 2000, and before January 1, 2001, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. Future updates will be published by CMS for services rendered on and after January 1, 2001.

Line 6.06--Enter the Medicare managed care days occurring before January 1 of this cost reporting period. Make no entry prior to January 1, 1998. This line equals Worksheet S-3, Part I, column 4, line 2 minus line 6.02 above. Do not complete this line for cost reporting periods ending on or after June 30, 2006.

Line 6.07--Enter the percentage using the criteria identified on line 6.04 above. For years prior to January 1, 2003, the percentage is always 20 percent less than the amount reported on line 6.04.

Line 6.08--Calculate the Graduate Medical Education payment for managed care days prior to January 1 of this cost reporting period: {(line 6.06/line 6.03) times line 6.07} times line 3.25. For services rendered on or after January 1, 2000, and prior to January 1, 2001, reduce the amount by the factor reported in the FR dated August 1, 2000, Vol. 65, section D and E, pages 47038 and 47039. For services on or after January 1, 2001, updates will be published by CMS. After reducing this amount by the Nursing and Allied Health Medicare Advantage (formerly Medicare + Choice) factor, for fiscal years ending on or after July 1, 2005, add to this amount the hospital's section 422 direct GME payment for managed care, if applicable, from line 12 of W/S E-3, Part VI. For cost reporting periods ending on or after June 30, 2006, this line will only reflect the hospital's section 422 direct GME payment for managed care, if applicable, from line 12 of W/S E-3, Part VI.

Direct Medical Education Costs for ESRD Composite Rate Title XVIII Only--This section computes the title XVIII nursing school and paramedical education costs applicable to the ESRD composite rate. These costs are reimbursable based on the reasonable cost principles under 42 CFR 413.85 separate from the ESRD composite rate.

#### Line Descriptions

Line 7--Enter the amount from Worksheet B, Part I, sum of columns 21 and 24, lines 57 and 64.

Line 8--Enter the amount from Worksheet C, Part I, column 8, sum of lines 57 and 64. This amount represents the total charges for renal and home dialysis.

Line 9--Divide line 7 by line 8, and enter the result. This amount represents the ratio of ESRD direct medical education costs to total ESRD charges.

Line 10--Enter from your records the Medicare outpatient ESRD charges.

Line 11--Enter the result of multiplying line 9 by line 10. This represents the Medicare outpatient ESRD costs. Transfer this amount to Worksheet E, Part B, line 22.

Apportionment of Medicare Reasonable Cost of GME--This section determines the ratio of Medicare reasonable costs applicable to Part A and Part B. The allowable costs of GME on which the per resident amounts are established include GME costs attributable to the entire hospital complex (including non-hospital portions of a health care complex). Therefore, the reasonable costs used in the apportionment between Part A and Part B include the hospital, hospital-based providers, and distinct part units. Do not complete this section for titles V and XIX.

### Line Descriptions

Line 12--Include the Part A reasonable cost for the entire hospital complex computed by adding the following amounts:

- o Hospital and Subprovider(s) - Sum of each Worksheet D-1, line 49;
- o Hospital-Based HHAs - Worksheet H-7, Part I, column 1, line 1;
- o Swing Bed-SNF - Worksheet D-1, line 62 (for cost reporting periods beginning prior to July 1, 2002) swing Bed-SNF - Worksheet E-2, line 1, column 1 (for cost reporting periods beginning on or after July 1, 2002);
- o Hospital-Based Non-PPS SNF - Worksheet D-1, line 82; and
- o Hospital-Based PPS SNF - Sum of Worksheet D-1, line 70 and Worksheet E-3, Part III, column 2, line 6.

Line 13--Enter the organ acquisition costs from Worksheet(s) D-6, Part III, column 1, line 61.

Line 14--Enter the cost of teaching physicians from Worksheet(s) D-9, Part II, column 3, line 16.

Line 15--Enter the total Medicare Part A primary payer amounts for the hospital complex from the applicable worksheets.

- o PPS hospital and/or subproviders - Worksheet E, Part A, line 17;
- o TEFRA hospital and/or subproviders - Worksheet E-3, Part I, line 5;
- o Cost reimbursed hospital and/or subproviders and Non-PPS SNFs - Worksheet E-3, Part II, line 5;
- o Hospital-based HHAs - Each Worksheet H-7, Part I, column 1, line 9;
- o Swing Bed SNF and/or NF - Worksheet E-2, column 1, line 9; and
- o Hospital-based PPS SNF - Worksheet E-3, Part III, column 2, line 7.

Line 16--Enter the sum of lines 12 through 14 minus line 15.

Line 17--Enter the Part B Medicare reasonable cost. Enter the sum of the amounts on each title XVIII Worksheet E, Part B, columns 1 and 1.01, sum of lines 1, 1.01, 1.07, 2 through 4; Worksheet E, Parts C, D, and E, columns 1 and 1.01 line 6; Worksheet E-2, column 2, line 8; Worksheet H-7, Part I, sum of columns 2 and 3, line 1; Worksheet J-3, columns 1 and 1.01 if applicable, lines 1 and 1.01, and Worksheet M-3, line 16.

Line 18--Enter the Part B primary payer amounts. Enter the sum of the amounts on each Worksheet E, Part B, line 24; Worksheet E-2, column 2, line 9; Worksheet H-7, Part I, sum of columns 2 and 3, line 9; and Worksheet J-3, line 2, columns 1 and 1.01 if applicable.

Line 19--Enter line 17 minus line 18

Line 20--Enter the sum of lines 16 and 19.

Line 21--Divide line 16 by line 20, and enter the result.

Line 22--Divide line 19 by line 20, and enter the result.

Allocation of Medicare Direct GME Costs Between Part A and Part B--Use this section to compute the GME payments for title XVIII, Part A and Part B, and to compute the total GME payments applicable to titles V and XIX.

#### Line Descriptions

Line 23--For cost reporting periods ending prior to January 1, 1998, multiply line 3 by line 6, and enter the result. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, line 54. Do not compute lines 24 and 25.

Line 23.01--For cost reporting periods that end on or after January 1, 1998, enter the sum of lines 6.01, 6.05, and 6.08. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, line 54. Do not compute lines 24 and 25.

Line 24--Complete for title XVIII only. Multiply line 23 or 23.01 by line 21, and enter the result. If you are a hospital subject to PPS, transfer this amount to Worksheet E, Part A, line 11. Although this amount includes the Part A GME payments for subproviders, for ease of computation, transfer this amount to the primary hospital component worksheet only. If you are freestanding facility subject to TEFRA, an LTCH PPS, IPF PPS, or IRF PPS, transfer this amount to Worksheet E-3, Part I, line 13. If you are subject to cost reimbursement, i.e., CAH, transfer this amount to Worksheet E-3, Part II, line 18.

Line 25--Complete for title XVIII only. Multiply line 23 or 23.01 by line 22, and enter the result. Transfer this amount to Worksheet E, Part B, line 21. Although this amount includes the Part B GME payments for subproviders, for ease of computation, transfer this amount to the hospital component only.

3633.5 Part V - Calculation of NHCMQ Demonstration Reimbursement Settlement for Medicare Part A Services--Use this part to calculate reimbursement if you are a part of the NHCMQ demonstration project for cost reporting periods beginning before July 1, 1998.

Part A - Inpatient Services: Provider Computation of Reimbursement--Use this part to calculate payment for title XVIII services furnished by NHCMQ Demonstration participants. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ Demonstration.

#### Line Descriptions

Line 1--Enter the number of total title XVIII inpatient days. Obtain this figure from Worksheet S-3, Part I, column 4, line 15.

Line 2--Enter the number of demonstration program days. Obtain this figure from Worksheet S-7, line 46, columns 3.01 and 4.01.

Lines 3 through 5--Calculate the net non-NHCMQ Demonstration Part A inpatient ancillary services. These include radiology, laboratory, intravenous therapy, oxygen, electrocardiology, medical supplies charged to patients, and drugs charged to patients and others.

Line 3--Enter the total Part A ancillary program costs. Obtain this figure from Worksheet D-4, column 3, line 101.

Line 4--Enter the physical, occupational, and speech therapy ancillary program costs. To obtain this figure, add lines 50, 51, and 52 on Worksheet D-4, column 3.

Line 5--Subtract line 4 from line 3, and enter the difference. This amount represents the net ancillary services not applicable to the NHCMQ Demonstration. Enter this amount on Worksheet E-3, Part III, column 2, line 2.

Line 6--Enter the NHCMQ Demonstration inpatient routine/ancillary PPS amount paid. Obtain this figure from Worksheet S-7, column 5, line 46.

Lines 8 through 9--Calculate the program inpatient capital costs. The capital costs are not part of the PPS calculation. Instead the capital costs flow through the cost finding stepdown process on Worksheet B.

Line 7--Do not use this line.

Line 8--Enter the per diem capital-related cost from Worksheet D-1, line 72.

Line 9--Enter the program capital-related cost. Obtain this amount by multiplying line 8 by line 1.

Lines 10 through 24--Calculate the indirect cost component of the demonstration ancillary services. The indirect cost component of the demonstration ancillary services is not part of the PPS calculation. Instead the indirect costs are passed through from cost finding on the cost report. For participants in the demonstration, ancillary services are calculated as part of the PPS payment beginning in phase 3. Lines 10 through 24 are completed only for phase 3.

Line 10--Enter the total general service cost allocation for physical therapy. Obtain this amount from Worksheet B, Part I, column 27, line 50.

Line 11--Enter the total general service cost allocation for occupational therapy. Obtain this amount from Worksheet B, Part I, column 27, line 51.

Line 12--Enter the total general service cost allocation for speech therapy. Obtain this amount from Worksheet B, Part I, column 27, line 52.

Line 13--Enter the direct cost for physical therapy. Obtain this amount from Worksheet B, Part I, column 0, line 50.

Line 14--Enter the direct cost for occupational therapy. Obtain this amount from Worksheet B, Part I, column 0, line 51.

Line 15--Enter the direct cost for speech therapy. Obtain this amount from Worksheet B, Part I, column 0, line 52.

Line 16--Enter line 10 less line 13. This is the physical therapy indirect cost for the entire reporting unit.

Line 17--Enter line 11 less line 14. This is the occupational therapy indirect cost for the entire reporting unit.

Line 18--Enter line 12 less line 15. This is the speech therapy indirect cost for the entire reporting unit.

Line 19--Enter the charge to charge ratio for physical therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 50 by the amount on Worksheet C, Part I, column 8, line 50.

Line 20--Enter the charge to charge ratio for occupational therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 51 by the amount on Worksheet C, Part I, column 8, line 51.

Line 21--Enter the charge to charge ratio for speech therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 52 by the amount on Worksheet C, Part I, column 8, line 52.

Line 22--Calculate the physical therapy demonstration indirect cost by multiplying line 16 by line 19.

Line 23--Calculate the occupational therapy demonstration indirect cost by multiplying line 17 by line 20.

Line 24--Calculate the speech therapy demonstration indirect cost by multiplying line 18 by line 21.

Line 25--Enter the sum of lines 6, 9, 22, 23, and 24. Transfer this amount to Worksheet E-3, Part III, line 24.

3633.6 Part VI – Direct GME and IME Payments related to MMA section 422 (Public Law 108-173) “Redistribution of Unused Residency Slots”--Use this worksheet in conjunction with Worksheet E-3, Part IV and Worksheet E, Part A to calculate payment for direct GME as determined under 42 CFR 413.75 through 413.83 and IME as determined under 42 CFR 412.105 for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under Section 422 of Public Law 108-173. Do not use this worksheet if the cost reporting period ends prior to July 1, 2005 or if the cost reporting period ends after July 1, 2005 but the hospital did not receive an adjustment to either the GME or IME cap under Section 422 of Public Law 108-173.

Line 1--Enter the ratio of the number of days from July 1, 2005 to the end of the cost reporting period divided by the total number of days in the cost reporting period. For example, for a cost reporting period of October 1, 2004 to September 30, 2005, enter .252055 (i.e., 92 days from July 1, 2005 to September 30, 2005 divided by 365 days in the cost reporting period). For cost reporting periods which do not overlap July 1, 2005, enter 1 on this line.

Lines 2-4 --Computation of reduced direct GME cap under 42 CFR §413.79(c)(3). Complete lines 2 through 4, only where Worksheet S-2, line 25.05, column 1, is “Y”.

Line 2--Reduced Direct GME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced direct GME cap as specified under 42 CFR §413.79(c)(3). However, if the resulting reduced direct GME cap is less than zero (0), enter zero on this line.

Line 3--Unadjusted Direct GME FTE Cap. Enter the unadjusted direct GME FTE Cap from

Worksheet E-3, Part IV, sum of lines 3.01 and 3.02.

Line 4 --For cost reporting periods that overlap July 1, 2005, enter the ratio on line 1 multiplied by the count on line 2. Add to this count the count on line 3 multiplied by the result of "1" minus line 1. This is the prorated cap for that fiscal year. For cost reporting periods beginning on or after July 1, 2005, enter the count on line 2. This is the hospital's reduced direct GME FTE cap.

Lines 5-12--Computation of additional direct GME payments for unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 CFR §413.79(c)(4). Complete lines 5 through 12, only where Worksheet S-2, line 25.06, column 1, is "Y".

Line 5--Section 422 Direct GME FTE Cap. Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap slots the hospital received under 42 CFR §413.79(c)(4).

Line 5.01-Prorated Direct GME FTE Cap. For cost reporting periods that overlap July 1, 2005, enter the result of multiplying the ratio on line 1 by the number on line 5 in order to establish the cap for the portion of the cost reporting period occurring after July 1, 2005. Use this line only when the cost reporting period overlaps July 1, 2005.

Line 6--Direct GME FTE Resident Count Over the Cap: Subtract line 3.06 on Worksheet E-3, Part IV from line 3.05 on Worksheet E-3, Part IV and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME 422 cap and lines 7 through 12 do not need to be completed.

Line 7--Section 422 Allowable Direct GME FTE Resident Count: If the count on line 6 is greater than the count on line 5, divide line 3.09 of Worksheet E-3, Part IV by line 3.05 of Worksheet E-3, Part IV, and multiply the resulting ratio by the amount on line 5 of this worksheet. If the count on line 6 is less than or equal to the count on line 5, divide line 3.09 of Worksheet E-3, Part IV by line 3.05 of Worksheet E-3, Part IV, and multiply the resulting ratio by the amount on line 6 of this worksheet. For cost reporting periods that overlap the July 1, 2005 effective date, substitute line 5.01 for line 5, in the calculation of line 7.

Line 8--Enter the locality adjusted national average per resident amount as specified at 42 CFR section 413.77(g), inflated to the hospital's cost reporting period.

Line 9--Enter the product of Line 7 and Line 8. This is the allowable section 422 GME cost.

Line 10--Enter the Medicare program patient load from Line 6 of Worksheet E-3, Part IV.

Line 11--Enter the product of line 9 and line 10. This is the section 422 direct GME payment for non-managed care days.

Line 12--Determine the direct GME payment for managed care days by multiplying line 9 by the managed care patient load computed from worksheet E-3, Part IV: [(line 6.02 + line 6.06)/line 5]. Reduce this amount by the Nursing Allied Health Medicare advantage factor. (See Worksheet E-3, Part IV, line 6.08).

Lines 13-15--Computation of reduced IME cap under 42 CFR §412.105(f)(1)(iv)(B). Complete lines 13 through 15, only where Worksheet S-2, line 25.05, column 2, is "Y".

Line 13--Reduced IME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced IME FTE resident cap for allopathic and osteopathic residents as specified under 42 CFR §412.105(f)(1)(iv)(B). However, if the resulting reduced direct GME cap is less than zero (0), enter zero on this line.

Line 14--Unadjusted IME FTE Cap. Enter the unadjusted IME FTE Cap from Worksheet E, Part A, sum of lines 3.04 and 3.05.

Line 15 --For cost reporting periods that overlap July 1, 2005, enter the ratio on line 1 multiplied by the count on line 13. Add to this count the count on line 14 multiplied by the result of “1” minus line 1. This is the reduced cap for that fiscal year. For cost reporting periods beginning on or after July 1, 2005, enter the count on line 13. This is the hospital’s reduced IME FTE cap.

Lines 16 - 23--Computation of IME payments for additional allopathic and osteopathic resident cap slots received under 42 CFR §412.105(f)(1)(iv)(C). Complete lines 16 through 23 only where Worksheet S-2, line 25.06, column 2, is “Y”.

Line 16--Section 422 IME FTE Cap--Enter the number of allopathic and osteopathic IME FTE residents cap slots the hospital received under 42 CFR §412.105(f)(1)(iv)(C).

Line 17--IME FTE Resident Count Over the Cap--Subtract Line 3.07 on Worksheet E, Part A from Line 3.08 on Worksheet E, Part A and enter the result here. If the result is zero or negative, the hospital does not need to use the 422 IME cap. Therefore, do not complete lines 18 through 23.

Line 18--Section 422 Allowable IME FTE Resident Count--If the count on line 17 is greater than zero, enter the lower of Line 16 or Line 17.

Line 19--Resident to Bed Ratio for Section 422--Divide Line 18 by Line 3 of Worksheet E, Part A.

Line 20--IME Adjustment Factor for Section 422 IME Residents--Enter the result of the following:  $.66 * [(1 + \text{Line 19})^{.405} - 1]$ .

Line 21--For cost reporting periods that overlap July 1, 2005, enter the amounts reported on Worksheet E, Part A, lines 1, 1.01 and 1.02, relating to discharges occurring on or after July 1, 2005. For cost reporting periods beginning on or after July 1, 2005, enter the sum of Worksheet E, Part A, lines 1 through 1.02.

Line 22--For cost reporting periods that overlap July 1, 2005, enter the amounts reported on Worksheet E, Part A, lines 1.03, 1.04 and 1.05, relating to discharges occurring on or after July 1, 2005. For cost reporting periods beginning on or after July 1, 2005, enter the sum of Worksheet E, Part A, lines 1.03 through 1.05.

Line 23--Enter the sum of lines 21 and 22, multiplied by the factor on line 20 and transfer to Worksheet E, Part A, line 3.24.